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September 26, 2019

The Honorable Larry Hogan, Governor
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Thomas V. Miller, Jr.
President
Senate of Maryland
State House H-107
Annapolis, MD 21401

The Honorable Adrienne Jones
Speaker
Maryland House of Delegates
State House H-101
Annapolis, MD 21401

RE: Report required by State Government Article 5-112 (MSAR #5566)

Dear President Miller and Speaker Jones,

In accordance with paragraph 2-1246 of the State Government Article, University of Maryland School of Public Health, Center for Health Equity Workgroup on Health in all Policies respectfully submits the September 30, 2019 report.

The University of Maryland School of Public Health, Center for Health Equity Workgroup on Health in All Policies (SB340) Act became effective June 1, 2017, and will end on June 30, 2019.

We want to take this opportunity to thank the members of the Workgroup for their cooperation and commitment.

Sincerely,

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Professor, Department of Health
Policy & Management
Director, Maryland Center for Health Equity
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College Park, MD 20742

cc: Sarah Albert Department of Legislative Services (5copies)
cc: Chair Senate Education, Health, and Environmental Affairs Committee (1 copy)
cc: Chair House Health and Government Operation Committee (1 copy)

SHIRLEY NATHAN-PULLIAM
Legislative District 44
Baltimore City and Baltimore County

Vice Chair
Education, Health, and
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September 30, 2019

I am happy to announce that a Health in All Policies model is now established in the State of Maryland. This is the result of SB340/HB1225 Health in All Policies which became law in 2017.

This was made possible by collaborating, and drawing on the collective resources of the agencies, departments, and organizations across the State who brought to the table an amazing array of expertise, experience, knowledge. The result was a range of ideas and solid data to operationalize this work.

When we think of wealth it is often expressed in terms of assets, estates, finances, goods money, possessions, property. However one very valuable thing not regarded as an asset is health. Without the asset of good health, no one would be able to work productively to build and structure resilient, and thriving communities, States, or Nations. Opportunities would be wasted on individuals too sick to engage, or optimize for earning and making money. Physical disabilities, and/or emotional/neurological disabilities would impede any progress necessary to move in a forward direction. Health is an asset, and a commodity. Health is Wealth!

Health in All Policies addresses the social determinants of health that are the key drivers of health outcomes and health inequities. A disparity in one of the areas of Social Determinants, such as zip code, can result in a twenty year difference in life expectancy.

A number of states and countries have implemented these sorts of taskforces and policies such as, California, Tennessee, Massachusetts, Washington D.C., Washington, Finland, Thailand, Australia, Brazil and more. Maryland now joins the group this this model for Health in All Policies.

This was a collaborative effort as I was lead sponsor in the Senate, and I applaud Delegate Robbyn Lewis as lead sponsor to cross file HB1225 in the House of Delegates. I would be remiss if I did not thank my colleagues at the General Assembly for the overwhelming support to unanimously pass this legislation.

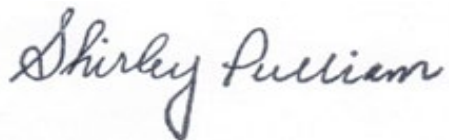
I am conveying a big “thank you” to the University of Maryland, College Park, President Dr. Wallace Loh, School of Public Health, Dean Boris Lushniak, and University of Maryland Center for Health Equity, Director Dr. Stephen Thomas, for taking on this daunting charge to see this initiative to fruition. Also, Mr. Wesley Queen, assistant to Dr. Thomas, I commend you for the tremendous job of coordinating the activities, and scheduling meetings of the Health in All Policies Workgroup. Further, accolades to Kristanna Peris, and Sarah Hurlbert, whose efforts produced the interim and final reports for the Health in All Policies Workgroup. Lastly, I thank, Elaine Zammett, my Chief of Staff.

I would like to salute Dr. Carlessia Hussein, former Director of the Office of Minority Health, who worked with me on the language that created the legislation.

I must acknowledge the many partners across various sectors who came together lending their time, collective experience, expertise, and most of all dedicated commitment to this project. I commend, the ongoing engagements and high quality of industry over the past two years to generate this report.

I again thank the many contributors to this project. I invite the public to review this tool to gain knowledge and leverage to implement future initiatives, and projects.

Sincerely,

A handwritten signature in cursive script that reads "Shirley Pulliam". The signature is written in black ink and is positioned above the typed name.

Shirley Nathan-Pulliam
Senator

SENATE BILL 340 / HOUSE BILL 1225:

**UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH,
CENTER FOR HEALTH EQUITY**

WORKGROUP ON HEALTH IN ALL POLICIES

September 30th, 2019 REPORT

Executive Summary
Senate Bill 340 / House Bill 1225
Health in All Policies Workgroup
September 30th, 2019 Report

SB340/HB1225 Legislation

Senate Bill 340 (SB340) and House Bill 1225 (HB1225) requires a workgroup of State and non-state agency representatives to work with the Health in All Policies (HiAP) framework to examine the health of Maryland residents and ways for “State and local government to collaborate to implement policies that will positively impact the health of residents of the state” (SB340 p. 2 (b)).

Recommendations

The Workgroup respectfully submits the following recommendations:

- 1.** The workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in choosing or developing a Maryland Health in All Policies Framework. The Workgroup recommends a purposed budget and funding plan.
- 2.** The Workgroup recommends that the Health in All Policies Toolkit be used by the new Health in All Policies Council and state agencies.

3. The Workgroup recommends that the new Health in All Policies Council use the developed optional addendum for the Maryland procurement process.

4. The Workgroup recommends that the Process to Facilitate Data Sharing within a Health in All Policies Framework be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing within a Health in All Policies Framework in State agencies.

5. Maryland localities consult the Health in All Policies toolkit and Reference Guide during the Comprehensive Planning and Zoning regulations development process.

Workgroup Process

The Workgroup met monthly to research and further develop the recommendations presented in the 2019 Maryland General Assembly. The four teams formed to devote specific attention to the 2018 recommendations continued to work together. Through individual team discussion, the Workgroup developed a list of recommendations and supporting documents.

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**SENATE BILL 340 / HOUSE BILL 1225:
UNIVERSITY OF MARYLAND SCHOOL OF PUBLIC HEALTH,
CENTER FOR HEALTH EQUITY -
WORKGROUP ON HEALTH IN ALL POLICIES**

SENATE BILL 340 / HOUSE BILL 1225

Senate Bill 340 (SB 340) and House Bill 1225 (HB 1225) from the 2017 session titled: “University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies,” presented to the Maryland General Assembly by Senator Shirley Nathan-Pulliam and Delegate Robbyn Lewis passed the Senate and House on third read in March 2017. Maryland Governor Lawrence Hogan signed the bill into law on May 4, 2017.

“This bill requires the University of Maryland School of Public Health’s Maryland Center for Health Equity (M-CHE), in consultation with the Department of Health and Mental Hygiene (DHMH), to convene a workgroup to study and make recommendations to units of State and local government on laws and policies that will positively impact the health of residents in the State.” The workgroup must use a “Health in All Policies framework” to “(1) examine and make recommendations regarding how health considerations may be incorporated into decision making; (2) foster collaboration among State and local governments and develop laws and policies to improve health and reduce health inequities; and (3) make recommendations on how” such laws and policies may be implemented. (SB340 Bill p.2, Fiscal and Policy Note, p. 1)

Workgroup Task

The Workgroup is tasked to examine the health of Maryland residents and develop ways for units of State and local government to collaborate using a Health in All Policies framework. The Workgroup was tasked to examine the impact of the following factors on the health of Maryland residents:

- 1) access to safe and affordable housing;
- 2) educational attainment;
- 3) opportunities for employment;
- 4) economic stability;
- 5) inclusion, diversity and equity in the workplace;
- 6) barriers to career success and promotion in the workplace;
- 7) access to transportation and mobility;
- 8) Social justice;
- 9) environmental factors; and
- 10) public safety, including the impact of crime, citizen unrest, the criminal justice system, and governmental policies that affect individual who are in prison or released from prison.

(SB 340 Legislation p. 2)

January 2019 Report Recommendations

The Health in All Policies Workgroup presented a report to the Maryland General Assembly on January 31, 2019 which included four recommendations based on work the Workgroup conducted in 2018. The 5th recommendation was not addressed. The Workgroup recommended:

- 1) The workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in developing a Maryland Health in All Policies Framework.
- 2) The Workgroup recommends that a Health in All Policies Toolkit be developed.
- 3) The Workgroup recommends that the Health in All Policies council develop an optional addendum for the Maryland procurement process.
- 4) The Workgroup recommends that the Process to Facilitate Data Sharing be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing.

RECOMMENDATIONS

SB340/HB1225 Health in All Policies workgroup legislation requires a report of the Workgroup's recommendations on or before June 30, 2019. An extension to September 30th was granted for the Final Report (See Appendix XXIII & XXIV).

The following recommendations are presented in accordance with the reporting requirement, as reported in the January 2018 report.

- 1. The workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in choosing or developing a Maryland Health in All Policies Framework. The Workgroup recommends a purposed budget and funding plan.**

This recommendation addresses the Workgroup's 2018 recommendation, "A Health in All Policies framework be developed and a Health in All Policies Council be created."

The workgroup recommends that a Health in All Policies Council consisting of a wide variety of stakeholders, including state government, community-based organizations, advocacy individuals, and public health and health equity experts be established to help implement and coordinate the statewide Health in All Policies program and activities. The individuals could be identified as "Health in All Policies Council."

The Workgroup recommends that the Centers for Disease Control and Prevention’s Policy Process guide the Council in developing or adapting a Maryland Health in All Policies Framework. The Framework will guide state agencies and other organizations to include health considerations in all policies and programs. This Framework may include prevention and early intervention strategies as well as statements of principles designed for each agency and organization.

2. The Workgroup recommends that the Health in All Policies Toolkit be used by the Health in All Policies Council and state agencies.

This recommendation addresses the Workgroup’s 2018 recommendation that “A toolkit with a reference guide be developed.”

The Health in All Policies toolkit has been developed to help state agencies, legislators, and policy directors understand what Health in All Policies is and how to implement Health in All Policies principals and strategies into their operations.

3. The Workgroup recommends that the new Health in All Policies Council use the optional addendum for the Maryland procurement process.

This recommendation addresses the Workgroup’s 2018 recommendation that “Funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.”

The workgroup recommends that the Health in All Policies Council further develop an addendum designed to collect information on efforts made by applicants responding to requests for proposals or other state procurement opportunities to consider broad health implications when making operational, supply, workforce, and other business decisions.

4. The Workgroup recommends that the Process to Facilitate Data Sharing within a Health in All Policies Framework be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing within a Health in All Policies Framework in State agencies.

This recommendation addresses the Workgroup’s 2018 recommendation that “A process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed.”

The workgroup created a document delineating a Process to Facilitate Data Sharing within a Health in All Policies Framework and recommends that this document be published for public viewing and for use by State agencies. This data sharing process document takes into consideration efficiency, effectiveness, and the implications of making decisions in order to improve population health and health equity.

The workgroup recommends that a task force be created to implement and evaluate the Process to Facilitate Data Sharing within a Health in All Policies Framework in state agencies. This task force may be a subcommittee of the Health in All Policies Council. Members of the task force should be familiar with data sharing.

5. Maryland localities consult the Health in All Policies toolkit and Reference Guide during the Comprehensive Planning and Zoning regulations development process.

The workgroup recommends that a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed to ensure health and nonhealth data are being shared to support health in all policies. Appropriate, efficient data sharing is crucial in developing policies that best address the needs of residents of the State. The workgroup recommends providing county and state agencies with templates of materials such as Memorandums of Understanding and Data Use Agreements to support agreements between agencies and provide guidance to agencies about how and why it is important to share data to address health problems. Additionally, the workgroup recommends that initially, this process may focus on publicly available data from population survey sources including, but not limited to, the Maryland Behavioral Risk Factor Surveillance System.

WORKGROUP PROCESS

The SB340/HB1225 Workgroup met monthly to discuss work-plans, collaborate, and create recommendations. Conference calls were held between the monthly meetings to maintain communication and assist members. The Workgroup was on recess during the months of February and March.

The workgroup continued to work on four different teams, each dedicated to one of the recommendations from 2017. The four teams were:

- 1) **Team C** – focused on creating a Health in All Policies Council and developing a Maryland Health in All Policies framework.
- 2) **Team T** – focused on creating a toolkit with a reference guide.
- 3) **Team F** – focused on creating funding announcements that encourage applicants to include a Health in All Policies framework in their funding proposals.
- 4) **Team D** – focused on developing a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies.

The monthly meetings allowed the teams to work together, develop the final product and receive feedback. Each team has created a document and recommendations that will guide future actions (see Appendix).

Content experts presented at several workgroup meetings. These presentations provided detailed information on specific topics relevant to the workgroup’s recommendations. Clifford Mitchell,

MS, MD, MPH of the Environmental Health Bureau in the Maryland Department of Health presented on the Maryland Environmental Public Health Tracking system. In a later meeting, Kristi Pier, MHS, MCHES and Caroline Green, MPH of the Center for Chronic Disease Prevention and Control in the Maryland Department of Health presented on the Healthiest Maryland Businesses program. Jamie Tomaszewski, Chief of Procurement, and Robert Gleason, Senior Procurement Executive of the Maryland Department of Budget and Management presented on the Maryland Procurement Process.

See the Appendix for meeting agendas and meeting minutes.

Team C

Team C worked on the Workgroup's recommendation that a Health in All Policies framework be developed and a Health in All Policies Council be created.

Team C developed guidance and a potential structure for the Health in All Policies Council. This structure includes a vision that will guide the Health in All Policies Council; as the purpose, membership and duties are developed and a potential framework that the Health in All Policies Council could adapt to guide its efforts.

Team C reviewed multiple prominent Health in All Policies Frameworks to inform their recommendation for a future Health in All Policies Council. Team C identified the Centers for Disease Control and Prevention's Policy Process,¹ to guide the Council on their choice or creation of a Framework. This is presented in Team C's Health in All Policies Framework and Council Structure in Appendix III of the document. Potential frameworks for the Council's consideration, that Team C discussed, are also identified in this report (in the appendix) to allow a future Health in All Policies Council to decide which framework it believes best suits its purpose. See Appendix III for Team C's Health in All Policies Framework and Council Structure.

The Workgroup collectively gave input on the purposed budget and purposed funding plan. A Council Summary sheet and FAQ sheet was also developed to inform potential funders about the Council. See Appendix IV for the Purposed Budget and Funding Plan and Appendix V for the one sheet and FAQ sheet.

¹ Centers for Disease Control and Prevention. Overview of CDC's Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012
<https://www.cdc.gov/policy/analysis/process/index.html>.

Team T

Team T worked on the Workgroup's recommendation that a toolkit with a reference guide be developed.

Team T gathered ideas for their toolkit by researching and reviewing existing state Health in All Policies toolkits. Specifically, Team T reviewed the Health in All Policies toolkit from California² and Tennessee.³ Reviewing these toolkits helped Team T determine elements that are typically included in a Health in All Policies toolkit.

Team T sent a survey to the Workgroup to gain a better understanding of the expectations members had for the toolkit and identified best-practices regarding toolkits currently in use in a variety of State agencies.

Team T combined the knowledge gained from reviewing other state's Health in All Policies toolkits with the survey results to create an outline for the Toolkit.

Team T used the information to create a Toolkit including a resource guide. The Toolkit was developed by a graduate student at the University of Maryland, College Park School of Public Health. The Toolkit was designed to be an aide to state agencies and legislators on matters of Health in All Policies. See Appendix VI for Team T's Maryland Health in All Policies Toolkit.

Team F

Team F worked on the workgroup's recommendation that funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.

Team F consulted with Ms. Jamie Tomaszewski, Chief of Procurement and Mr. Robert Gleason, Senior Procurement Officer at the Maryland Department of Budget and Management and leaders of the Healthiest Maryland Businesses program to determine how a Health in All Policies approach may be considered in the procurement process while maintaining competition.

Team F created a worksheet as an optional addendum in the State procurement process. The optional worksheet is designed to collect information for state procurement opportunities to consider health in making operational, business, supply, workforce, and other decisions. See Appendix VII for Team F's optional procurement document.

² <http://www.phi.org/resources/?resource=hiapgguide>.

³ <https://www.nashville.gov/Portals/0/SiteContent/Health/PDFs/NashVitality/HealthyToolkit.pdf>.

Team D

Team D worked on the Workgroup's 4th recommendation; to develop a process to provide guidance to state and county agencies to facilitate data sharing between and within agencies.

Team D considered members' experience, other individual's experience, advice, opinions, and advice when determining the data sharing challenges that would need to be addressed by a process to facilitate data sharing. Team D developed a process to facilitate data sharing that takes into accounts for efficiency, effectiveness, and the implications of making decisions in order to improve population health and health equity. Team D's goal was to ensure that whenever a new project, program, or policy is being developed, health considerations, environmental impacts, and potential outcomes are considered during their formulation and that existing data be made available to the decision makers for consideration during the process.

Team D created a seven-step Process to Facilitate Data Sharing within a Health in All Policies Framework. The Process was collaboratively created, solicited input from a select Focus Group which included a cross-section of state sectors (whose work benefits from data sharing when making decisions related to the resident of Maryland). This Focus Group consisted of members within the Workgroup as well as individuals and state mandated advisory councils' members (including the Commission for Environmental Justice and Sustainable Communities [CEJSC] and Children's Environmental Health and Protection Advisory Council [CEHPAC]). The Focus Group members provided expertise and/or engage in data sharing and have experienced barriers to accessing necessary data in their daily work.

This seven-step Process to Facilitate Data Sharing within a Health in All Policies Framework is explained in the Team D Data Sharing Process Document in Appendix VIII.

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Appendix I: Executive Summary and Priorities List from January 2018 Report

Executive Summary Senate Bill 340 Health in All Policies Workgroup January 2018 Report

SB340 Legislation

Senate Bill 340 (SB340) requires a workgroup of State and non-state agency representatives to work with the Health in All Policies (HiAP) framework to examine the health of Maryland residents and ways for “State and local government to collaborate to implement policies that will positively impact the health of residents of the state” (SB340 pg2 (b)).

Recommendations

The workgroup respectfully submits the following recommendations for the Maryland Legislature’s consideration. The SB340 Health in All Policies Workgroup recommends:

1. A Health in All Policies Framework be developed and a Health in All Policies Council be created.
2. A toolkit with a reference guide be developed.
3. Funding announcements encourage applicants to include a Health in All Policies framework in their funding proposals.
4. A process to provide guidance to state and county agencies to facilitate data sharing between and within agencies be developed
5. Maryland localities consult the Health in All Policies toolkit and Reference Guide during the Comprehensive Planning and Zoning regulations development process.

Health in All Policies Framework HiAP is a framework through which policymakers and public and private stakeholders collaborate to improve health outcomes and reduce health inequalities in the State by incorporating health considerations into decision making across sectors and policy areas. (SB340, pg. 2 (b))

Workgroup Process

The workgroup met monthly (June – December 2017) to learn from relevant content experts and apply the HiAP framework to the work-plan. Through individual team discussion and a subsequent survey, the workgroup developed a list of recommendations.

Health in All Policies in Other States

Maryland is one of several states to adopt a HiAP framework to impact population health. California, Washington, Massachusetts, and Oregon each have implemented the Health in All Policies framework in different ways and to varying extents. Generally, these states focus on transportation, the environment, and nutrition.

Other Items for Consideration

1. Vision Zero is a public health campaign/program, Maryland Department of Transportation already incorporates Vision Zero for pedestrian fatalities, we recommend that we expand the Vision Zero campaign to other state and county agencies that are not transportation related (i.e. promote with housing agencies to deal with safety issues at crosswalks, parking lots, etc.)
2. Implement well-resourced, evidence-based interventions that address leading determinants of health, such as food security and nutrition, housing, education, access to jobs, and transportation. (Note: Refer to World Health Organization’s exhaustive list of social determinants and the new Centers for Disease Control and Prevention guidebook).
3. The Public Service Commission regulates gas, electric, telephone, water, and sewage disposal companies. Also subject to the jurisdiction of the Commission are electricity suppliers, fees for pilotage services to vessels, construction of a generating station and certain common carriers engaged in the transportation for hire of persons. The Commission has the authority to issue a Certificate of Public Convenience and Necessity (CPCN), which provides authority for a person to construct or modify a new generating station or high-voltage transmission lines. We recommend that a Health Impact Assessment or Environmental Justice Assessment be conducted whenever a CPCN is issued to ensure associated projects do not compromise public health.
4. Select one issue and do an assessment of local programs to see how they handle Health in All Policies and suggest best practices to facilitate across county agencies and the state. We could focus on one issue as a case study.
5. Better understand how hospitals are partnering with social services agencies to facilitate affordable housing under global budget waiver
6. Leverage existing employee tuition benefits or other educational programs to encourage staff from all agencies to pursue Master of Public Health or Master of Health Administration degrees so that we have public health trainees in all agencies, even “non-health” agencies
7. Leverage scout volunteer or other youth activities (i.e. Youthworks) going on at other agencies and focus on health issues
8. Consider ways to ensure health-focused advertising is occurring via free advertising sources. For example, agencies get free ad space on buses and bus shelters; we could ensure free advertising space is used to promote culturally competent, health literate, health-related messages
9. Assure inclusion of those with disability in all programs and activities, assuring representation from organizations serving those with disabilities
10. Work through Human Resources staff to coordinate across agencies around health issues, perhaps we can start with injury prevention and safety in common job classifications throughout the state/counties/cities, and then convene the HR managers to focus on broader health issues since Human Resources is one department that exists in all agencies. Create committee made up of Human Resources staff/managers from all agencies.
11. Focus on health and wellness when doing employment and job skills training
12. Benefits counseling by agencies tends to be siloed, application process is unique to programs and localities. We should try to do a better job coordinating, similar to Maryland Access Point where they already coordinate programs for older adults.

13. Add social determinants of health and health in all policies training to licensure requirements for doctors, nurses, chiropractors, day care providers, teachers, etc.
14. Committee to ensure child care, Family and Medical Leave Act, nursing and other health-related child development activities can be coordinated and prioritized. Could coordinate through Department of Budget and Management and Transportation Service Human Resource System for Human Resources.
15. Systematic and sustained action is needed to achieve food and nutrition security for all in the US and particularly in Maryland. Interventions are needed including adequate funding for and increased utilization of food and nutrition assistance programs, inclusion of food and nutrition education in such programs, and innovative programs to promote and support individual and household economic self-sufficiency
16. Registered dietitians and dietetic technicians must play key roles in ending food insecurity and they are uniquely positioned to make valuable contributions through provision of comprehensive food and nutrition education; competent and collaborative practice; innovative research related to accessing a safe, secure, and sustainable food supply; and advocacy efforts at the local, state, regional, and national levels
17. Implement a pilot study/project with Baltimore City Government, where there are likely the most concentrated health disparities and inequities in the state
18. We would like to develop language to introduce Health in All Policies into State Government planning for integrated pest management. This would include actions at the County level and with similar requirements as stated for the Public Service Commission above
19. Education Article Section § 5-312 (with definitions in § 3-602.1) requires new state- funded school construction to meet or exceed the Leadership in Energy and Environmental Design (LEED) Silver rating (or state equivalent).
 - a. Under US Green Building Council LEED/Schools, indoor air quality (IAQ) construction management is an optional credit that projects can choose but is not a requirement. Additionally, when it comes to schools, certain LEED credits – specifically those related to IAQ, integrated pest management (IPM), and Green Cleaning should be made mandatory – that is be made to be a “prerequisite” rather than a “credit”.
 - b. Currently buildings can qualify for LEED certification without selecting any Indoor Environmental Quality credits. This is unacceptable for schools and can be remedied by making certain LEED credits prerequisites. Maryland must consider the impact to the building occupants as well as energy efficiency, etc. The building should have a positive impact on public health as well as the environment.
20. Education Article Section 5-112 Green Cleaning Procurement for Public Schools: Education Article § 5-112 establishes guidelines for purchasing green products cleaning supplies in public schools. To improve children's health, it should be expanded to include day care centers and other areas where children spend their time. Additionally, clarification is needed so that schools would understand that air- fresheners should not be allowed in schools. Greater guidance on

disinfecting wipes and soaps is also needed.

21. Maryland should address the issues identified in the Final Report of the Advisory Committee on the Management and Protection of the State's Water Resources (Wolman Report 2008). Access to clean drinking water, protection of ground water, streams and the bay is vital to public health.
22. Maryland should address the issues identified in the first state-wide assessment of Children's environmental health, Maryland's Children and the Environment (August 2008). The Report concluded (refer to page 4) "Maryland has made significant progress in reducing children's exposures to some environmental hazards. However, there are limitations in the state's capacity to conduct surveillance on important and emerging environmental hazards and exposures, as well as health outcomes. Maryland's investments in monitoring and surveillance have taken us part of the way in understanding children's environmental health in the state. We are aware of important trends and important differences by region and population group. It is important for public health policy to be guided by the best available science, supported by effective surveillance and dialogue. We hope that the indicators presented in this document advance the public dialogue and lead to improvements in children's environmental health."
23. Maryland Department of Agriculture (MDA) Regulations 15.05.02 School Integrated Pest Management (IPM) Law
 - a. This regulation needs to be improved because it only covers the academic year (e.g. allows pesticide applications without notification on school gardens outside the academic year), prohibits the use of pest control products that are exempt from Environmental Protection Agency (EPA) registration and continues to allow for the routine application of pesticides in school buildings and on school grounds, and does not cover pesticide applications to a school's artificial turf athletic fields (as they are currently exempt from this regulation).
 - b. Per MDA practices, School Districts are not required adopt an IPM Policy as required by the statute. Some pesticide applications such as those for mosquito control, tick control and artificial turf fields not covered by regulations. Requesting that the MDA address the weaknesses in the School IPM regulations as these concerns do impact children's health.
24. MDA Regulations 15.05.01.15 Posting of Signs (for pesticides applied to turf)
 - a. Signage is not sufficient to adequately inform the public and protect the public from unintended contact with pesticides. Expanded signage options for organic pest control applications should be developed so that the public knows which areas are treated with conventional pesticides and which are treated with organic means of pest control, some of which are exempt from EPA registration.
 - b. Commercial pesticide applications should be required to post the product name on the yellow "turf flag" along with their company name, phone number and date of application. The regulations should be modified so that members of the public who come in contract with a posted turf pesticide application sign can call and promptly obtain the Product Label and Material Safety Data Sheet (MSDS or SDS) for the products applied. Currently, this information is not

available to the public, however, such information is vital to health care providers should someone experience a negative reaction or wish to protect themselves from contact with the pesticide applied.

25. Per the MDA regulations (2011's SB 546) - Fertilizer can be applied from November 16 through December 1 a maximum of 0.5 pound per 1,000 square feet of water soluble nitrogen (no slow release) may be applied.

Issue - this regulation does not consider organically maintained turf and the application of compost as a fertilizer outside of the regulation designated window for the application of a fertilizer. Healthy soil is a key component impacting public health (i.e. air, water, soil, food, etc.) The law is being used to minimized runoff of nutrients, but unlike most states Maryland is not exempting compost — therefore treating compost the same as other fertilizers. There are so many benefits of compost from a human and environmental health standpoint. Regulations should address compost independent of conventional fertilizers.

26. MDA Pesticide Sensitive Individual Notification Report (15.05.01.17)

- a. This program should be simplified and made accessible to all residents of Maryland. Access to the form and the written requirements (ex. physician's certifications, list of neighbor's names and addresses, etc.) makes it difficult for most Marylanders to apply and receive notifications of a pesticide application made to a property contiguous to their residence or obtain the product label (PL) and Safety Data Sheet (SDS) for the product being applied. Protection from unintentional exposure to pesticides from such applications or from the drift from such applications is vital to public health.

27. The Maryland Children's Environmental Health and Protection Advisory Council (CEHPAC) respectfully requests that the Maryland Department of Agriculture (MDA) review existing regulations pertaining to the Pesticide Applicator's Law (15.05.01) and Integrated Pest Management (IPM) and Notification of Pesticide Use in a Public School (15.05.02) to ensure that pesticide applications made to synthetic (or artificial) turf fields including those on public school grounds are regulated in the same manner as pesticide applications made to natural turf fields and other public school grounds. CEHPAC requests that the MDA take prompt action to clarify the regulations as necessary correct to this situation (Source: Letter CEHPAC to MDA 12/13/16)

28. CEHPAC recommends that the Maryland Department of Health and Mental Hygiene asks the United States Department of Human Services to formally petition the Federal Communications Commission (FCC) to revisit the exposure limit to ensure it is protective of children's health and that it relies on current science. [Source: CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report (December 13, 2016) page 8]

29. CEHPAC recommends that the Maryland State Department of Education should recommend that local school systems:

- a. Consider using wired devices
 - i. Where classrooms are powered, but without wired access to the school networks, a centralized switch and dLAN units can provide a reliable

and secure form of networking for as many laptops as necessary without any microwave electromagnetic field exposure

- ii. If a new classroom is to be built, or electrical work is to be carried out in an existing classroom, network cables can be added at the same time, providing wired network access with minimal extra costs and time
- b. Have children place devices on desks to serve as a barrier between the device and children's bodies
- c. Locate laptops in the classroom in a way that keeps pupil heads as far away from the laptop screens (where the antennas are) as practicable
- d. Consider using screens designed to reduce eyestrain
- e. Consider using a switch to shut down the router when it is not in use
- f. Teach children to turn off Wi-Fi when not in use
- g. Consider placing routers as far away from students as possible
- h. Share this document with teachers and parents.

[Source: CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report (December 13, 2016) page 8]

30. CEHPAC recommends the General Assembly should consider funding education and research on electromagnetic radiation and health as schools add Wi-Fi to classrooms [Source: CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report (December 13, 2016) page 8]

31. CEHPAC recommends that the Maryland Department of Health and Mental Hygiene should provide suggestions to the public on ways to reduce exposure:

- a. Sit away from Wi-Fi routers, especially when people are using it to access the internet
- b. Turn off the wireless on your laptop when you are not using it
- c. Turn off Wi-Fi on smartphones and tablets when not surfing the web
- d. Switch tablets to airplane mode to play games or watch videos stored on the device

[Source: CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report (December 13, 2016) page 9]

32. CEHPAC recommends that the Maryland CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report be posted on the Council website and shared with the:

- a. United States Department of Health and Human Services
- b. Federal Communications Commission
- c. Maryland State Department of Education
- d. Maryland General Assembly

[Source: CEHPAC Wi-Fi Radiation in Schools in Maryland Final Report (December 13, 2016) page 9]

Appendix II: Executive Summary of January 2019 Report

Executive Summary 2017's Senate Bill 340 / House Bill 1225 Health in All Policies Workgroup January 2019 Report

2017's SB340/HB1225 Legislation

Senate Bill 340 (SB340) and House Bill 1225 (HB1225) requires a workgroup of State and non-state agency representatives to work with the Health in All Policies (HiAP) framework to examine the health of Maryland residents and ways for “State and local government to collaborate to implement policies that will positively impact the health of residents of the state” (SB340 p. 2 (b)).

Recommendations

The Workgroup respectfully submits the following recommendations:

1. The workgroup recommends that a Health in All Policies Council be established, consisting of a wide variety of stakeholders. The Workgroup recommends a process that will assist the Health in All Policies Council in choosing or developing a Maryland Health in All Policies Framework
2. The Workgroup recommends that a Health in All Policies Toolkit be developed based on the outline created by the Workgroup.
3. The Workgroup recommends that the new Health in All Policies council develop an

optional addendum for the Maryland procurement process.

4. The Workgroup recommends that the Process to Facilitate Data Sharing within a Health in All Policies Framework be made available for use by State agencies and that a task force within the Health in All Policies Council be responsible for implementing and evaluating the Process to Facilitate Data Sharing within a Health in All Policies Framework in State agencies.

Workgroup Process

The Workgroup met monthly to research and further develop the recommendations presented to the 2018 Maryland General Assembly. Four teams were formed to devote specific attention to four of the 2018 recommendations. Through individual team discussion, the Workgroup developed a list of recommendations and supporting documents.

Next Steps

The Workgroup will continue to develop its recommendations until the Workgroup ends in June 2019. The Workgroup will submit a Final Report with Recommendations to the Maryland General Assembly in June 2019.

Appendix III: Team C Health in All Policies Frameworks and Council Structure

EXECUTIVE SUMMARY

The Centers for Disease Control and Prevention’s Policy Process⁴ was identified to assist the Council in the development of a Health in All Policies Framework recommended for consideration to guide state agencies and other organizations to include health considerations in all policies and programs. The Workgroup has also identified four possible Frameworks that the Council may want to consider. These Frameworks can be found in the appendices.

A Health in All Policies Council should be formed and include representation from state agencies; local and community-based organizations; community members; and individuals with experience and interest in the HiAP process.

HIAP COUNCIL

The Workgroup discussed and decided that not only senior-level individuals be included in the HiAP Council composition but also representatives that have an understanding of the populations and communities that HiAP activities will affect. These could be individuals of any organizational or community representation that will serve as the “Health in All Policies Council”

Health in All Policies Council Vision:

The Health in All Policies Council will commit to health and health equity as a priority by adopting the principles of Health in All Policies and acting on the social determinants of health to alleviate the challenges and inequity/experienced due to lack of resources and access to:

- (i) access to safe and affordable housing;
- (ii) educational attainment;
- (iii) opportunities for employment;
- (iv) economic stability;
- (v) inclusion, diversity, and equity in the workplace;
- (vi) barriers to career success and promotion in the workplace;
- (vii) access to transportation and mobility;
- (viii) social justice;
- (ix) environmental factors; and
- (x) access to comprehensive health insurance and health care.

⁴ <https://www.cdc.gov/policy/analysis/process/index.html>

Health in All Policies Council Purpose and Duties:

Implement and coordinate the Maryland Health in All Policies (HiAP) Program and activities.

- a. Embed an approach to health equity in the culture and policy of Department / Organization portfolios
- b. Establish shared integrated goals for collaboration
- c. Build platform to address the social determinants of health in a systematic manner
- d. Advise and operationalize the HiAP Report and recommendations
- e. Repository of HiAP best practices – model policies and vision statements
- f. Work with toolkit team to determine who will be developing these model practices
- g. Agenda and goal setting for practical application (how to implement it)
- h. Council will develop the metrics and targets.
- i. Host an annual meeting with feedback from participants.
- j. Involving LHO to report out on how the communities are being affected

Council Representation:

Council members should be:

- Initially from the workgroup
- Use the workgroup representation
- Senior level and non-management

Council seats should include:

- All state agencies listed in original workgroup legislation
- Elected officials
- CHWs representing urban and rural
- Community level individuals representing Constituencies (2)
- Community advocate
- Transportation
- Energy
- Food justice
- Faith-based
- Public Safety
- Housing
- Epidemiologist

FRAMEWORK RECOMMENDATION

The Workgroup recommends that the Centers for Disease Control and Prevention Policy Process be used by the HiAP Council to assist in the identification of a Health in All Policies Framework. Additionally, the Workgroup has provided four possible frameworks for consideration in the appendices.

The Centers for Disease Control and Prevention have developed a Policy Process as it recognizes policy as an effective way to improve the health of populations through a variety of avenues and understands that often the domains of the policy cycle overlap or occur out of order.



The following provides a summary of the five domains to the CDC’s Policy Process⁵.

I. Problem Identification: Clarify and frame the problem or issue in terms of the effect on population health.

- Collect, summarize, and interpret information relevant to a problem or issue (e.g., nature of the problem, causes of the problem)
- Define the characteristics (e.g., frequency, severity, scope, economic and budgetary impacts) of the problem or issue
- Identify gaps in the data
- Frame the problem or issue in a way that lends itself to potential policy solutions

II. Policy Analysis: Identify different policy options to address the problem/issue and use quantitative and qualitative methods to evaluate and the policy options to determine the most effective, efficient, and feasible option.

- Research and identify policy options
- Describe: a) how the policy will impact morbidity and mortality (health impact), b) the costs to implement the policy and how the costs compare with the benefits (economic and

⁵ Centers for Disease Control and Prevention. Overview of CDC’s Policy Process. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2012
<https://www.cdc.gov/policy/analysis/process/index.html>

budgetary impacts) and c) the political and operational factors associated with adoption and implementation (feasibility)

- Assess and prioritize policy options

III. Strategy and Policy Development: Identify the strategy for getting the policy adopted and how the policy will operate.

- Identify how the policy will operate and what is needed for policy enactment and implementation (e.g., understand jurisdictional context and identify information and capacity needs)
- Define strategy for engaging stakeholders and policy actors
- Draft the policy (law, regulation, procedures, actions, etc.)

IV. Policy Enactment: Follow internal or external procedures for getting policy enacted or passed

- Enact law, regulation, procedure, administrative action, incentive, or voluntary practice

V. Policy Implementation: Translate the enacted policy into action, monitor uptake, and ensure full implementation.

- Translate policy into operational practice and define implementation standards
- Implement regulations, guidelines, recommendations, directives and organizational policies
- Identify indicators and metrics to evaluate implementation and impact of the policy
- Coordinate resources and build capacity of personnel to implement policy
- Assess implementation and ensure compliance with policy
- Support post-implementation sustainability of policy

The following are **overarching domains** that should be considered as appropriate.

- Stakeholder Engagement and Education: Identify and connect with decision-makers, partners, those affected by the policy, and the general public.
 - Identify key stakeholders, including supporters and opponents (e.g., community members, decision-makers, nonprofit, and for-profit agencies)
 - Assess relevant characteristics (e.g., knowledge, attitudes, needs)
 - Implement communication strategies and deliver relevant messages and materials
 - Solicit input and gather feedback
- Evaluation: Formally assess the appropriate steps of the policy cycle, including the impact and outcomes of the policy.

- Define evaluation needs, purpose, and intended uses and users
- Conduct evaluation of prioritized evaluation questions (e.g., was the problem defined in a way that prioritized action, how were stakeholders engaged, is the policy being implemented as intended, what is the impact of the policy)
- Disseminate evaluation results and facilitate use

Optional Framework Appendices

Alternative Frameworks for Council Consideration

1. Nine Questions to Guide Development and Implementation of Health in All Policies⁶
2. Health in All Policies: A Guide for State and Local Government⁷
3. ASTHO: Health in All Policies – A Framework for State Health Leadership⁸
4. Frieden T. A Framework for Public Health Action: The Health Impact Period⁹

⁶ Evelyne De Leeuw, Dorothee Peters; Nine questions to guide development and implementation of Health in All Policies, Health Promotion International, Volume 30, Issue 4, 1 December 2015, Pages 987–997, <https://doi.org/10.1093/heapro/dau034>

⁷ <http://www.phi.org/resources/?resource=hiapguide>

⁸ <http://www.astho.org/HiAP/Framework/>

⁹ A framework for public health action: the health impact pyramid. Am J Public Health. 2010;100(4):590-5. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/>

Appendix IV: Purposed Council Budget & Funding Plan

Estimated needs for funding HiAP Council is \$125,000 per year

Includes:

- | | |
|---------------------------------------------------------------|-----------|
| • Salary for 1.5 FTEs (FT Coordinator and graduate student) - | \$100,000 |
| • Meeting Expenses - | \$10,000 |
| • Report Preparation Costs - | \$15,000 |

Organizations to target for funding primarily health care orgs:

- Kaiser Permanente
- Aetna
- Care First
- United Health Care
- Baltimore Gas & Electric
- Wells Fargo Social Responsibility Fund

Additional sources for financial leads:

- Maryland Municipal League, Maryland Association of Counties, Enterprise Community Partners, and Institute for Public Health Innovation

Timeline:

July 2019 - Develop one-pager to use for fundraising

August 2019 - Create sponsorship “package” to use in fundraising pitch
 Outreach to consultation organizations for leads
 Outreach to target organizations - identify sponsorship/grant process and parameters and begin submissions as appropriate
 Map out future submissions as needed

January 2020 Have funding commitments ready
 Prepare to engage Maryland General Assembly for matching support

Appendix V: HiAP Council Summary Sheet and FAQ Sheet

HiAP Council Summary Sheet starts on next page.

Maryland Health in All Policies Council

Goals of the Council

THE Health in All Policies (HiAP) Council will address health and health equity as a priority by adopting the principles of Health in All Policies and acting on the social determinants of health to alleviate the challenges and inequity/experienced due to lack of resources and:

Access to safe and affordable housing;

Educational attainment;

Opportunities for employment;

Economic stability;

Inclusion, diversity, and equity in the workplace;

Barriers to career success and promotion in the workplace;

Access to transportation and mobility;

Social justice;

Environmental factors; and

Public safety including comprehensive health insurance and health care.

Defining HiAP

Health in All Policies is a Public Health Framework through which policymakers and public and private stakeholders "use a collaborative approach to improve health outcomes and reduce health inequities in the State by incorporating health considerations into decision making across sectors and policy areas" (1).

At its simplest, Health in All Policies is an approach to policy-making that incorporates health considerations into all decisions across all sectors (2).

1. S.B. 340, 2017 Maryland General Assembly, Regular Session.

2. University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies. January 2018 Report, <https://sph.umd.edu/sites/default/files/images/che/HiAP/SB340%20Report%20FINAL%201.29.18.pdf>

Maryland Health in All Policies Council

What the HiAP Council is Looking For:
Community Support
Funding Sources

What the HiAP Council Needs Funding For:

Personnel Cost
Meeting Locations
Other Operating Cost

Estimated Minimum Budget: \$125K



Frequently Asked Questions

Who is a part of the Council?

Senior-level and non-management individuals may be included in the HiAP Council composition, also representatives that understand the populations and communities that HiAP activities will affect. Council members come from diverse backgrounds including; State Agencies, Community Advocates, Transportation, Energy, Food Justice, Public Safety, Housing, Researchers, and many others.

Are there National Guidelines or Standards for Health in All Policies?

The Center for Disease Control and Prevention (CDC) has many resources on how to implement HiAP. The National Prevention Strategy also provides frameworks that can be employed by HiAP agencies. These sources were considered when purposing the Maryland HiAP Council. The American Public Health Association (APHA) has a guide available designed to help state and local governments. Both the CDC and APHA have links to those reports and others developed by State and International organizations. Links to the CDC and APHA HiAP pages are below.

CDC: <https://www.cdc.gov/policy/hiap/index.html>

APHA: <https://www.apha.org/topics-and-issues/health-in-all-policies>

Who will have access to reports produced by the Council?

The reports and other documents produced by the Council will be publicly available. Currently the January 2018 and 2019 reports created by the SB 340 Workgroup are available on the University of Maryland School of Public Health Centre for Health Equity (M-CHE) website. The link to the work group page is linked below. The January 2018 Report is also available on the MD Online Manual along with other information on the work group.

M-CHE: <https://sph.umd.edu/center/che/health-all-policies-workgroup>

MD Manuel Online:

<https://msa.maryland.gov/msa/mdmanual/26excom/defunct/html/20healinall.html>

Where in the Maryland State Legislative process will the Council have a role?

The HiAP Council may reevaluate and formulate an answer to this question upon its creation.

How will the Council measure it's outcomes?

The HiAP Council may reevaluate and formulate an answer to this question upon its creation.

Appendix VI: Team T Toolkit

Toolkit starts on next page.



Health in All Policies

A Guide for Implementation

University of Maryland School of Public Health | Center for Health Equity
Workgroup on Health in All Policies (SB340/HB1225)

ACKNOWLEDGMENTS

Toolkit Outline

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HiAP Workgroup Documents:

Maryland Center for Health Equity's HiAP Workgroup page: <http://sph.umd.edu/center/che/health-all-policies-workgroup>

January 2018 report: http://mgaleg.maryland.gov/ess06-pubs/Universities/SB340Ch559HB1225Ch558_2017.pdf

January 2019 report: [http://mgaleg.maryland.gov/ess06-pubs/Universities/SB340Ch559HB1225Ch558\(2017\)_2019.pdf](http://mgaleg.maryland.gov/ess06-pubs/Universities/SB340Ch559HB1225Ch558(2017)_2019.pdf)

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EXECUTIVE SUMMARY

What is Health in All Policies (HiAP)?

HiAP is a collaborative approach to improve the health of all communities by incorporating health, sustainability, and equity in decisions across sectors and policies areas. ¹ HiAP's goal is to ensure that decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process. A HiAP approach also identifies ways in which decisions on multiple sectors affect health and health equity and how these sectors can benefit from better health. ¹

Why is HiAP Needed?

A single government department cannot solve complex and multi-causal problems such as chronic-disease epidemic, aging population, growing inequality, health inequities, and climate change. ² HiAP is way to address the root cause of these problems known as the social determinants of health (SDoH). SDoH are circumstances in which people are born, live, learn, work, play, worship, and age. ³ They affect people's potential to be healthy by determining their level of access to resources to be healthy. ⁴ SDoH include political, socioeconomic, and cultural factors, as well as accessible healthcare and education systems, a fair justice system, safe environmental conditions, well-designed neighborhoods, and availability of healthy food. ⁵ To address the SDoH, HiAP proposes to advance collaboration and build sustained partnership among various government areas from the beginning of projects. ²

What Makes HiAP Different?

A HiAP approach ensures that health, equity, and sustainability are routinely, consistently, and intentionally considered in policymaking. HiAP's goal is to embed health considerations early in the processes of planning and development of all programs and policies. ¹ Health equity "means that everyone has the fair and just opportunity to be

as healthy as possible." ^{6(pp2)} Sustainability refers to creating and maintaining conditions for future generations to able to maintain and/or achieve health equity. ¹

HiAP's core advantages are ⁷: a) it allows for identification of common areas of investment and mutual benefit; b) it improves government efficiency and accountability; c) it is likely to minimize unintended health consequences of policies and projects; d) it benefits the economy by promoting the health of individuals and communities; e) it is ethically oriented and addresses the root causes of inequities.

HiAP Key Principles

There is not a right way to implement HiAP because it is a flexible process that targets the needs of each community. ¹

Its key principles are:

- a) promotion of health, equity, and sustainability
- b) cross-sector collaboration
- c) benefit multiple partners
- d) engage stakeholders
- e) create structural and procedural change

HiAP Best Practices

HiAP initiatives are flexible, developed within political and community contexts, and address specific communities' needs. ⁸ Effective HiAP implementation best-practices include but are not limited to:

- a) creating and sustaining partnerships ⁹
- b) engaging the community and other stakeholders ^{1,10}
- d) effective leadership and development of workforce capacity ¹¹
- c) strategic use and allocation of human, financial and informational resources ¹²⁻¹⁴
- d) identifying opportunities for change beyond the health care sector ^{1,14}
- e) measuring and evaluating outcomes ^{12,14}

ABOUT THIS GUIDE

Maryland Workgroup on Health in All Policies

In May 2017, Senate Bill 340/House Bill 1225 (SB340/HB1225) was signed into law.¹⁵ It required that a Health in All Policies (HiAP) workgroup be convened by the University of Maryland School of Public Health's Maryland Center for Health Equity (MCHE) in consultation with the Maryland Department of Health (MDH). The law emphasized the use of a HiAP collaborative approach to ensure that policymakers and stakeholders in the public and private sectors who engage with government initiatives include health considerations into decision making across sectors and policy areas.

The workgroup mandate was¹⁵:

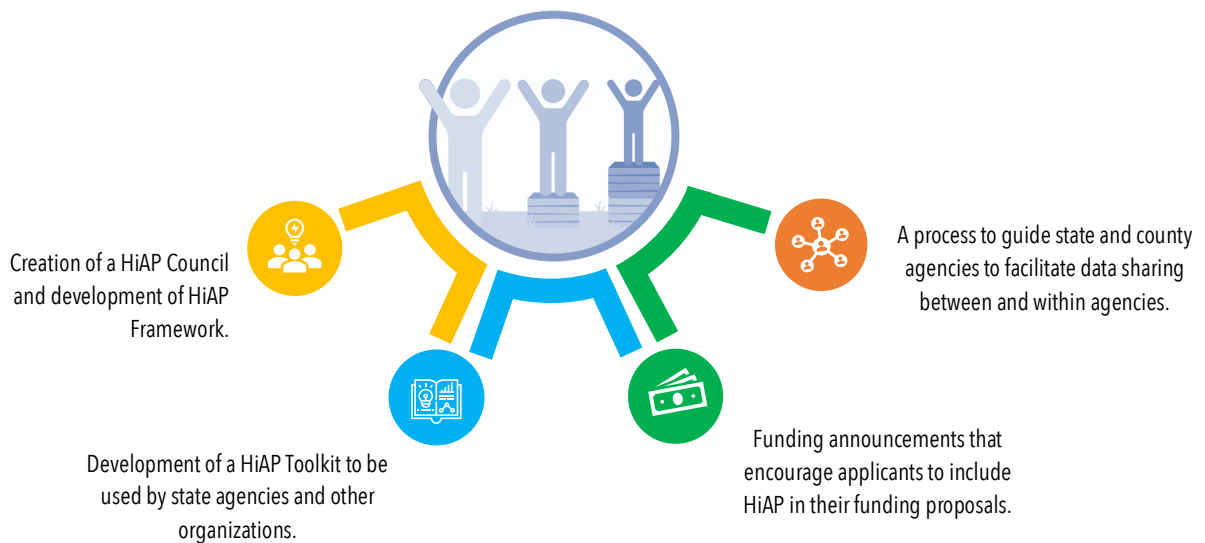
(1) examine and make recommendations regarding how health considerations may be incorporated into decision making processes

(2) foster collaboration among state and local governments and develop laws and policies to improve health and reduce health inequities

(3) make recommendations on how such laws and policies may be implemented

The HiAP Workgroup, which consisted of mandated representatives of state agencies and a variety of invited non-state agencies, had a structured work process extensively documented on the reports submitted to the general assembly.^{16,17} The group issued recommendations and guidance to institutionalize HiAP in Maryland (Box 01). The creation of guide is one of them.

Box 01: Recommendations for Institutionalizing HiAP in Maryland



MCHE - Maryland HiAP Workgroup, 2019

Purpose of This Guide

This guide conveys the Maryland HiAP Workgroup vision for HiAP. It was created to support Maryland State Agencies and Departments to become familiarized with HiAP processes and to be a starting point for HiAP implementation. This guide is a resource developed for state government decision-makers and staff, but local governments, community members, partners, and any other professionals interested in learning more about HiAP may also benefit from it (Box 02).



Box 02: The Audience

This guide's focus audience is:

- 1) Government agencies leadership, staff and other decision-makers seeking to implement HiAP in Maryland
- 2) Users that want to further knowledge about HiAP.



Box 03: Purpose of this Guide

With this guide, you will be able to:

- 1) Understand HiAP's concepts, goals, and principles
- 2) Understand the central role of collaboration in addressing complex problems
- 3) Understand the concept of health equity
- 4) Be familiarized with HiAP key elements
- 5) Understand HiAP's most common best practices

There are many guides and toolkits to help with implementing HiAP. Maryland HiAP guide incorporates concepts and suggestions proposed in some of these previous works as well as concepts from academic literature to (Box 03):

- a) provide HiAP concepts and goals
- b) describe HiAP key elements
- c) outline HiAP best practices
- d) provide HiAP examples in Maryland
- e) list resources

HiAP key elements and best-practices draw upon the CDC Policy Process¹⁸ and other frameworks identified and listed by the workgroup in its recommendations for the creation and operation of a Maryland HiAP Council.^{16,17} The Council will guide HiAP practices in Maryland, and it will be responsible for defining content and periodicity of updates in this guide.

There are many ways to incorporate HiAP into policy practice. For this reason, Maryland's HiAP guide is not prescriptive. The guide instead presents HiAP as an approach and a process that focus on changing government systems by incorporating health considerations at initial stages of programs and policies, but that can also be used to improve ongoing procedures and practices

Intersectoral collaboration is a central component of regular practice to address the root causes of health problems. This tool will help you and your organization to start in the path of promoting sustainable change in the way governments make decisions that impact the life of residents in communities throughout Maryland.

BACKGROUND

What is Health in All Policies?

HiAP is a collaborative approach to improve the health of all communities by incorporating health, sustainability, and equity in decisions across sectors and policy areas.¹ HiAP is represented by initiatives where multiple government sectors, private sector, non-government organizations, and civil society work together to address complex health problems.¹⁹

Government decisions impact the health of communities in many areas.¹⁰ Some of these areas are education, housing, transportation and mobility, work, economic growth and sustainability, food production and access to food, leisure

areas and parks, climate change, air, and water quality, and criminal justice. Similarly, healthier communities support the production of vibrant local economies and productive systems, which positively impact the outcomes of policies in all sectors.⁷

A HiAP approach can aid government sectors and their partners to recognize shared aims and to collaborate to advance shared and sector-specific goals while promoting better health.¹



Box 04: Health in All Policies (HiAP) Defined by MD SB340/HB1225

Health in All Policies is a “public health framework through which policymakers and stakeholders in the public and private sectors use a collaborative approach to improve health outcomes and reduce health inequities in the State by incorporating health considerations into decision making across sectors and policy areas.”^{15(pp1(b))}

How is HiAP Different?

Health in All Policies is one way to advance policies that can impact health. Specific policies that address health issues such as tobacco and alcohol use have made significant advances in reducing health risks.²⁰⁻²²

While issue-specific efforts have made remarkable achievements, this kind of initiative is vulnerable to changes in political will, land funding availability, to cite two.²³ This vulnerability happens because issue-specific initiatives do not impact governments' decision-making processes. Changing how the government takes decisions that impact health, equity, and sustainability is what HiAP intends to do.

HiAP requires an understanding of the political landscape within communities and flexibility to respond to local context and community needs.⁸ HiAP has many forms, levels of formality, and scale because initiatives are developed to address specific communities' needs.^{1,2} It can be a collaboration on a project, program or policy, or a comprehensive approach with the goal of changing how decisions take health into consideration.

The common ground on HiAP, and what makes it different, is its intentional and explicit focus on equity and sustainability.² HiAP ensures that health, equity, and sustainability are routinely, consistently, and intentionally considered in policymaking early in the processes of planning and development of all programs and policies.^{1,19} The long term goal is to embed health considerations in all policies.²⁴

One great advantage of HiAP is that through its processes, government agencies can identify common areas of investment.⁷ Identification of common areas of investment results in mutual benefit because it allows for the creation of synergic policies while also improving government efficiency and accountability.²⁵ Additionally, HiAP collaborative practices



Box 05: HiAP

The main difference: A HiAP approach to decision-making ensures that health, equity, and sustainability are routinely, consistently and intentionally considered in policymaking over the long term by embedding health considerations early in the processes of planning and development of all programs and policies.

The long-term goal: HiAP's long term goal is to embed health considerations in all policies.

HiAP core advantages:

- Allows for identification of common areas of investment and mutual benefit
- Improves government efficiency and accountability
- It is likely to minimize unintended health consequences of policies and projects
- Benefits the economy by promoting the health of individuals and communities and increasing their productive life
- It is ethically oriented and addresses root causes of inequities

of planning and evaluation are likely to minimize unintended health consequences of policies and projects.

Finally, health is fundamental for well-being. Being healthy enables people to work, study, be productive, enjoy life, and live longer.⁷ Societies guided by principles of fairness and justice aim for creating and maintaining conditions for all of its members to have the "fair and just opportunities to be as healthy as possible."^{6(pp2)} They also aim to sustain the same chances for future generations (Box 06).¹ It is clear that societies and communities prosper and maintain thriving economies when people are healthy and vice-versa.²⁶ Thus, HiAP also makes economic and ethical sense.



Box 06: Health Equity and Sustainability

Health Equity "means that everyone has the fair and just opportunity to be as healthy as possible."^{6 (pp2)}

Sustainability refers to creating and maintaining conditions for future generations to achieve and maintain health equity.¹

HiAP KEY ELEMENTS

HiAP can be a single-issue, project, policy or program collaboration^{1,14} or comprehensive efforts to change governance and structures to routinely include health in decision-making.^{1,27} While there is not any right way to implement a HiAP approach, promising HiAP practices are follow five core principles^{8,19,25,28}:

1. Promote Health, Equity, and Sustainability

Promoting equity and sustainability is an essential part of HiAP given the strong ties between inequity and poor health outcomes for all members of society. HiAP promotes equity and sustainability by incorporating them into policies and by institutionalizing decision making geared towards these values until it becomes the norm.^{1,2}

2. Cross-sector collaboration

HiAP brings together partners from the many sectors that play a significant role in shaping structures that affect the SDoH.² A HiAP approach aims to foster sustainable collaboration among the various government sectors.

Public health practitioners play a unique role in improving the communities' quality of life and in advancing equity.¹⁴ However, efforts to improve health must be made in partnership with other sectors. During and after relationship building a key public health sector's role in HiAP is to improve public health literacy. This means that public health departments should provide the information needed to support decisions that benefit the health of the communities^{29,30} by making its expertise available to other sectors.^{14,25} Health departments will help partners to understand:

- a) how health and health equity are created
- b) benefits and risks of participation in a HiAP initiative.¹

Box 07: Key HiAP Elements



Promotion of health, equity, and sustainability.



Cross-sector collaboration



Benefit multiple partners.



Engage stakeholders.



Create structural and procedural change

3. Defining Mutually Beneficial Goals

HiAP initiatives strive to address the policy and programmatic goals of both public health and other agencies by finding and implementing strategies that benefit multiple partners.^{24,25} Finding a balance between multiple goals is sometimes challenging. Sustainable change requires continually cultivating and maintaining respect and understanding in cross-sectoral relationships.¹

4. Engaging stakeholders

Stakeholders are agencies, groups, or individuals not yet engaged in a specific HiAP initiative, but that may be related to impacted by this initiative.¹ They can be state, local, or federal agencies, community organizations, nonprofit leaders, faith-based organizations, academic institutions, policy experts, advocates, members of the private sector, or funders. Stakeholders engagement is fundamental to safeguard that a HiAP work is responsive to community needs and to identify policy and systems changes necessary to create significant health advances.¹

5. Creating Procedural Change

Overtime HiAP creates permanent change in the way different sectors relate to each other and affects how decisions are made. To achieve this change, structures for intersectoral collaboration and mechanisms for using health and equity lenses in decision making should be sustained.^{1,2}

WHY IS HIAP NEEDED?

Problems like chronic illnesses epidemic, aging population, growing inequality, rising costs of medical care, health inequities, and climate change are multi-causal and challenging to solve.¹⁰ The solution to these problems and other similar challenges are beyond the range of action – and budget – of a single organization or government department.⁷

Governments around the world and in the U.S. have already acknowledged the role of policies outside the health care sector in influencing these complex problems.^{2,31} HiAP is one path for government areas to seek synergies and shift their operations to improve population health.³²

Ignoring how policies affect health is costly. The treatment of adults with obesity-related illnesses cost 342 billion in 2013, an increase of 28.2% when compared with

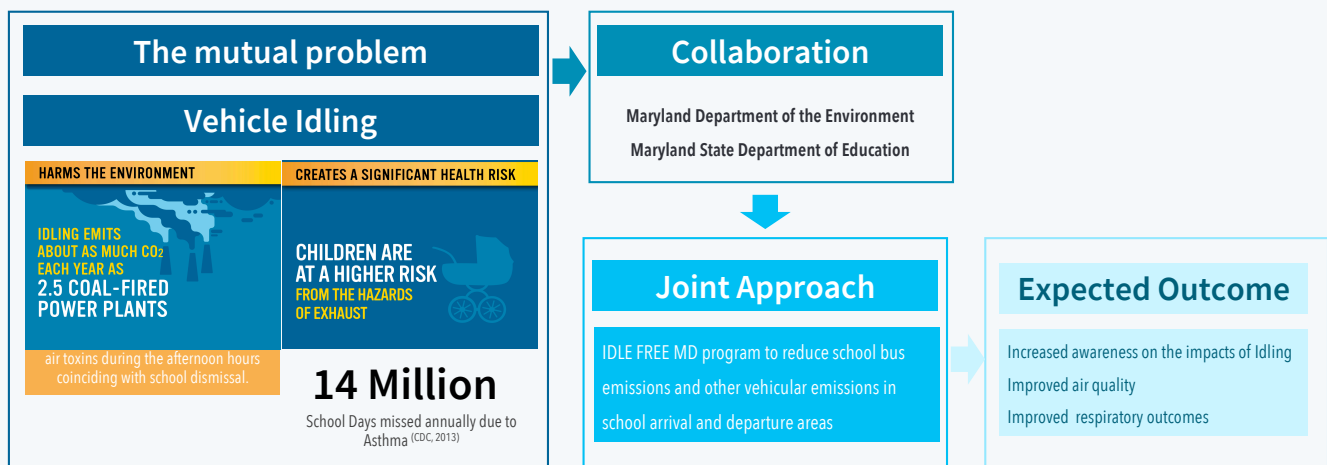
2005.³³ In the same period, asthma was responsible for \$3 billion in losses due to missed work and school days, \$29 billion due to asthma-related mortality, and \$50.3 billion in medical costs.³⁴ Obesity has multiple causes, including access to quality, affordable and nutritious food, access to recreation, and community's influence on behaviors.³⁵ Asthma and environmental factors are associated.³⁶ Many public agencies and policies can play a role in reducing the risk of developing obesity and asthma which reinforces the importance of including health considerations in all decision-making and policies across government sectors. Box 08 presents one initiative to tackle environmental factors related to asthma that can potentially advance goals of both partnering agencies and positively impact communities.

Box 08:

HiAP in Maryland - Idle free initiative



Idling is when a driver leaves the engine running and the vehicle parked. Idling represents a significant health issue for children and people with existing respiratory issues like asthma and emphysema. The Maryland Department of the Environment (MDE) and the Maryland State Department of Education are collaborating on a new Idle Free MD program to reduce school bus emissions and other vehicular emissions in school arrival and departure areas. MDE is also collaborating with



Sources:

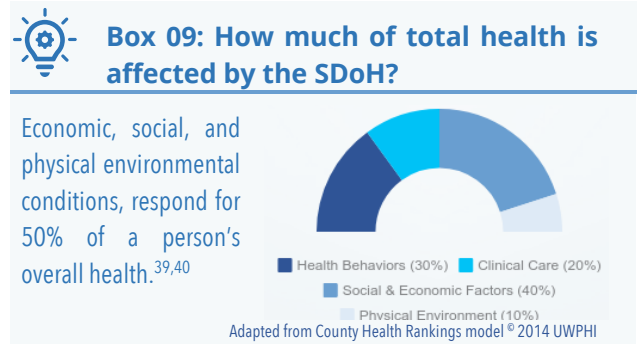
- ³⁷ CDC. Asthma-related Missed School Days among Children aged 5-17 Years | CDC. https://www.cdc.gov/asthma/asthma_stats/missing_days.htm.
- ³⁸ Maryland Department of the Environment. Idle Free MD Campaign. <https://mde.maryland.gov/programs/Air/MobileSources/idlefreeMD/Pages/index.aspx>.

The Social Determinants of Health (SDoH) and Inequity

The SDoH are the circumstances in which people are born, live, learn, work, play, worship, and age.³ They influence communities' and individual's potential to be healthy by determining the degree to which they have access to physical, social, and personal resources to identify and achieve personal goals, fulfill life needs, and interact with the environment.⁴ Box 09 shows that the SDoH alone are responsible for nearly 50% of a person's overall.^{39,40}

SDoH acts through instrumental mechanisms (available affordable healthy food, stable healthy housing, safe working conditions, etc.) and through chronic stress mechanisms (long-term effects of chronically elevated cortisol and adrenaline).¹¹ Figure 01 details Healthy People 2020' five main SDoH domains⁴²: economic stability, education, health and health care, neighborhood and built environment, and social and community context.

SDoH interact in a complex way. They are an underlying cause of today's major population health problems, including obesity, heart disease, diabetes, and depression.⁴⁴ For example, poor health or lack of education can impact employment opportunities, which in turn, limit income.⁵ Low income reduces access to healthcare and access to healthful food which i increases hardship. Hardship causes stress, which, in turn, promotes unhealthy coping mechanisms such as substance abuse and overeating of unhealthy foods.

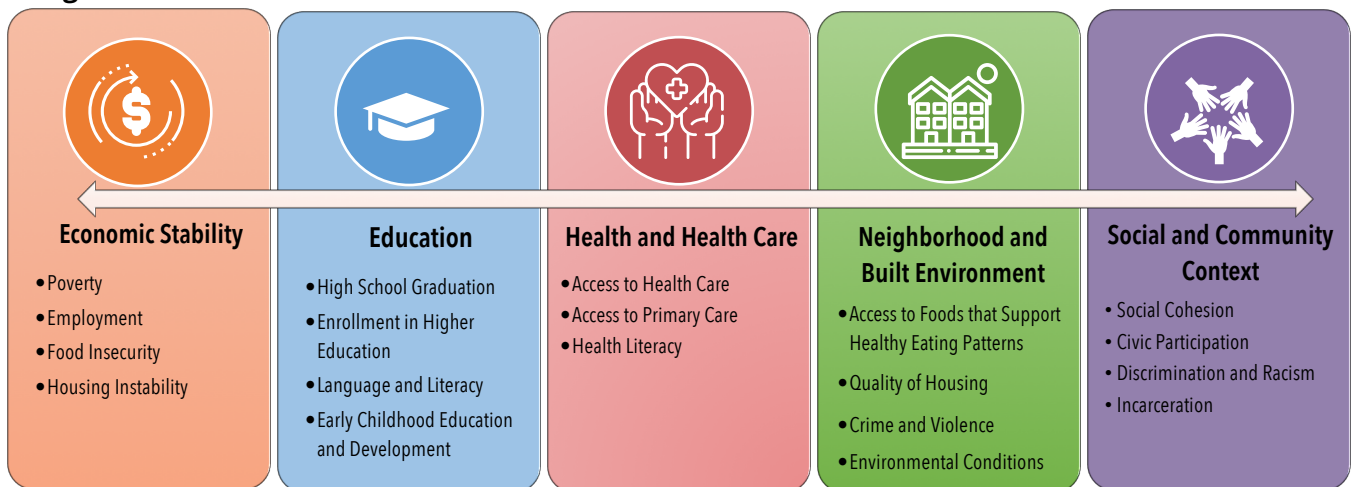


Adverse living conditions cause chronic stress. Stress increases the risk of poor birth outcomes and the risk for many chronic diseases in all age groups, including diabetes, hypertension, heart disease, cancer, and premature mortality.^{28,44-46}

Economic stability is associated with better overall health.¹⁰ Education, health and economic stability are linked: better health favors higher educational attainment and economic well-being. Higher educational attainment is associated with higher life expectancy.⁴⁷

The built environment and neighborhood are direct characteristics of communities. They influence the adoption of behaviors that impact health. For example, low-income neighborhoods have less healthy food outlets⁴⁸ and less green spaces⁴⁹. Both of these factors are linked to a higher risk of developing obesity and heart problems.^{50,51} ZIP code alone can determine a 20-year difference in life expectancy.^{40,52}

Figure 01: The Social Determinants of Health



Source: Healthy People 2020.

Inequity in the conditions of daily living is shaped by deeper social structures and processes that generate *structural inequities*.¹⁰ These structures and practices are systematic, “produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources.”^{10(pp.10)} Whether intended or not, structural inequities promote the unfair distribution of and access to power, wealth, and other necessary social resources.^{10,11}

By unfairly benefiting one population and unfairly disadvantaging other, structural inequities limit opportunities for health and create health disparities and health inequities.^{10,11} Structural inequities are often accompanied by racism, discrimination, social exclusion, poverty and low wages, lack of affordable housing, exposure to hazards, and community social decay.⁵³

Health disparities are health differences that adversely affect socially and economically disadvantaged groups.^{6,54} Health inequity is a particular kind of health disparity. *Health inequities* are avoidable, unfair, and unjust differences in health which stem from social norms, practices and economic, social, and environmental policies that create barriers to opportunities to be as healthy as possible.^{6,10,55} Box 10 summarizes the concepts discussed

Boxes 11 and 12 show some disparities and inequities in Maryland. Maryland has the second-highest median

household income (HHI) of the country, but it also has counties where the HHI is 1.5 times below the national HHI and 2.1 times below the state average.⁵⁶⁻⁵⁸ These counties have worse health outcomes when compared to high income counties. In Maryland, an African-American (non-Hispanic Black) is 1.9 times more likely to not see a doctor due to cost than a White person.⁵⁹ From 2008 to 2017, the infant mortality rate (IMR) has risen by 28% among Hispanics and for African Americans it is 2.8 times the IMR of Whites.⁶⁰ The maternal mortality rates (MMR) have declined in Maryland since 2012, but have not declined among African American women, and between 2012 and 2016 the African Americans’ MMR was 3.8 times the MMR of White women.⁶¹

The U.S. history of racism, slavery, and oppression left a legacy of biased policies that contribute to racial, social, and structural inequities. Acknowledging and addressing racism and bias promote health, equity and sustainability.⁵³

Health equity is the principle underlying a commitment to reduce – and, ultimately, eliminate – disparities in health and in its determinants. Policies and practices aimed at promoting health equity will not immediately eliminate all health inequities, but they provide a foundation for moving closer to this goal.¹



Box 10: Structural Inequities, Health Disparities and Health Inequities

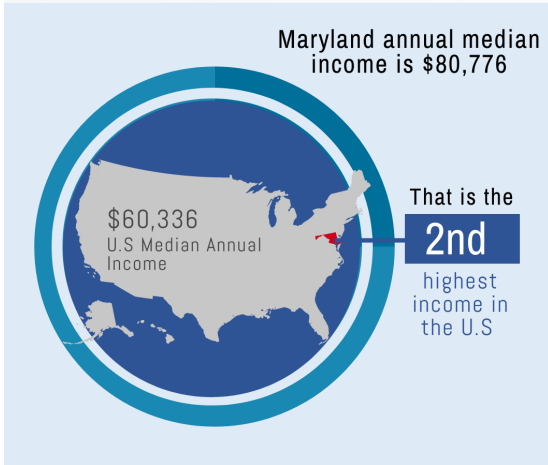
Structural inequities are “social structures or systems of society– such as finance, housing, transportation, education, health care, social opportunities, etc. – that are structured, typically through policies and systems, such that they unfairly benefit one population and unfairly disadvantage other populations (whether intended or not).”^{11(pp7)}

Health disparities are differences in health outcomes that adversely affect socially and economically disadvantaged groups “including differences that occur by gender, sexual orientation, age, race or ethnicity, education or income, disability, or living in various geographic localities or other characteristics associated with discrimination or marginalization.”^{54(ppS150)}

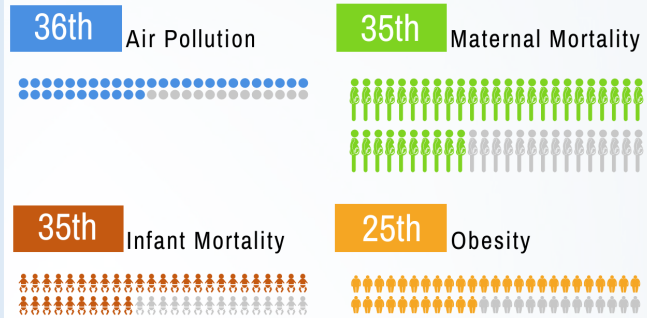
Health inequities are avoidable, unfair and unjust differences in health that stem from social norms, policies and practices which create barriers to opportunities.^{6,10,55}

Box 11:

MARYLAND SNAPSHOTS

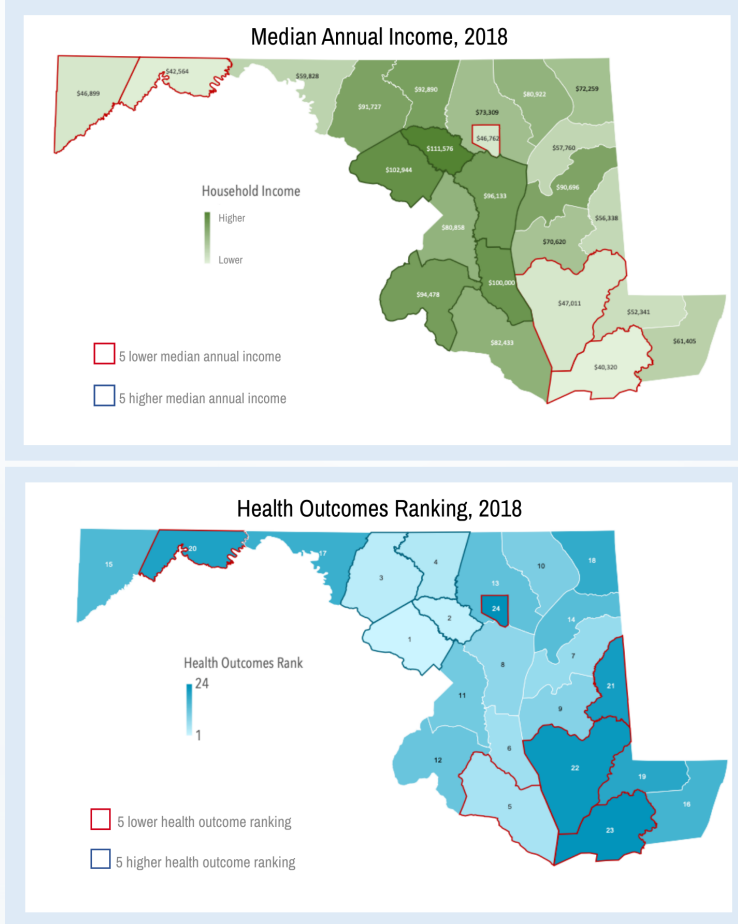


Maryland 2018 Rankings: Environmental, Behavioral and Health Outcomes Challenges



Persistent Inequities by Place

Counties With Lower Annual Income Rank Lower for Health Outcomes



Sources:
⁵⁶ U.S. Census Bureau, 2017 American Community Survey and 2017 Puerto Rico Community Surveys.
⁵⁷ America's Health Rankings, 2018.
⁵⁸ County Health Rankings, 2018.

MARYLAND SNAPSHOT

Persistent Health Disparities and Inequities by Race and Ethnicity

The Black and White Difference

Compared to non-Hispanic Whites, non-Hispanic Blacks are:



- 84% more likely to have DIABETES
- 51% More likely to be OBESE
- 39% more likely to die from BREAST CANCER
- 1.9 times more likely to not be able to afford to see a doctor within the past year
- 2.9 times more likely to die from ASTHMA
- 9.8 times More likely to be diagnosed with HIV

The Hispanic and White Difference

Compared to non-Hispanic Whites, Hispanics are:

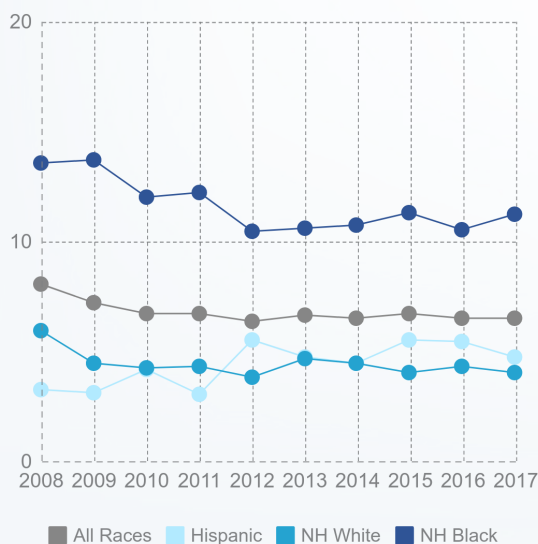


- 41% More likely to have DIABETES
- 13% More likely to be OBESE (among 18-44 year olds)
- 67% More likely to have never had a Mammogram (among women ages 40 and older)
- 3.1 times more likely to not be able to afford to see a doctor in past year
- 21% less likely to rate their general health as "excellent or very good"
- 3.4 times More likely to be diagnosed with HIV

The Average Infant Mortality Rate (IMR*) Decreased by 7% Between 2008 and 2017

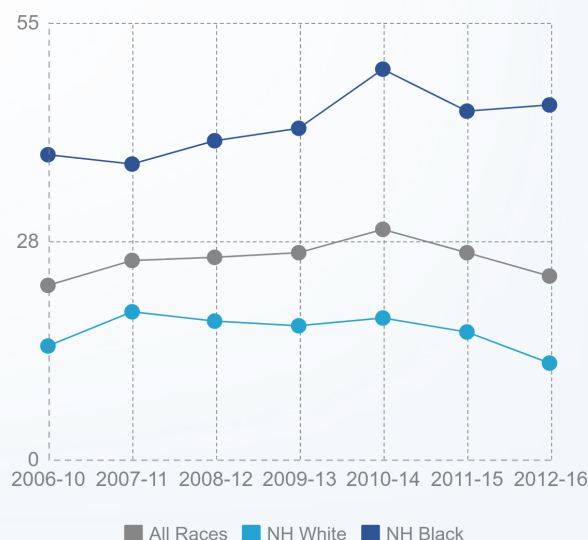
In 2017, NH Black IMR was **2.8 times** the White IMR

From 2008 to 2017 Hispanic IMR has risen by **28%**



Maternal Mortality Rate (MMR**) Decreased by 7.6% Between the 5 Year Periods of 2007-11 and 2012-16

Between 2012-16, the NH Black Women MMR was **3.7 times** the NH White MMR



*IMR is the number of all infant deaths, per 1,000 live births.

**MMR is the number of deaths from any cause related to or aggravated by pregnancy, per 100,000 births

Source:

⁵⁹ Maryland Department of Health. Health Equity Data. <https://health.maryland.gov/mhhd/Pages/Health-Equity-Data.aspx>.

⁶⁰ Maryland Department of Health. Infant Mortality in Maryland, 2017; 2018:04. https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Infant%20Mortality/Infant_Mortality_Report_2017_20180919.pdf

⁶¹ Maryland Department of Health. Maryland Maternal Mortality Review 2018 Annual Report; 2018:21. <https://phpa.health.maryland.gov/documents/Health-General-Article-%C2%A713-1207-2018-Annual-Report-Maryland-Maternal-Mortality-Review.pdf>

POLICIES AND HEALTHY COMMUNITY

Healthy Community

Social factors and communities' characteristics drive health outcomes and equity. HiAP at its core is a way of addressing the SDoH and promoting healthy communities. A healthy community is one in which local groups from all parts of the community work together to prevent disease and make healthy living options accessible.⁶² A healthy community, provides for all people to meet their basic needs through all stages of life.¹ It considers important community, societal, interpersonal, political, and personal factors such as the quality of the environment and sustainability factors, adequate levels of economic and social development, social relationships that are supportive and respectful, health and social equity (Figure 02).⁶³



Box 13: Health and Equity Lens

Looking through a health lens means “providing evidence that allows people to consider the positive and negative health and equity consequences of their decisions during the decision-making process (...) A health lens can be applied to any issue or sector and as well as to programs, projects, and administrative or legislative policies.”^{1(pp81)}

A “health lens” is a way to find opportunities to improve health and equity and incorporate these principals in decision-making (Box 13).¹ Using a “health and equity lens” allows for decision makers to create and promote healthy communities.

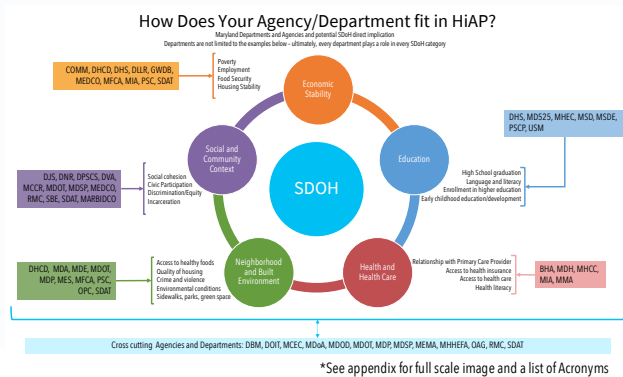
Figure 02: Some Elements of a Healthy Community



Analyzing the Health Implications of Policies

Any new or existing policy has the potential to affect the SDoH. These interferences can both support or negatively impact health and well-being. Figure 03 shows some of the Maryland state agencies and departments by policy area and possible influence on SDoH domains.

Figure 03: Maryland agencies and departments by policy area and SDoH domain.



Not all projects will have health implications, but all of them should evaluate if there are any possible health impacts. In some cases there may be regulations in place that require conducting a formal analysis (e.g., Environmental Impact Assessments are required for federally funded development and infrastructure projects).¹ When these requirements exist, the opportunity to incorporate a health and equity perspective to the analysis is already established.

The engagement of communities and other stakeholders will be crucial to bring health into consideration when: a) formal requirements are not present, b) the timeline of projects is too far along, c) in the presence of other barriers such as lack of resources.¹⁴ In any case, the earlier the analysis is performed more likely it is that it identifies relevant issues that affect health. This process can potentially identify and prevent unintended consequences of programs and policies

because it allows for considering the distribution and equity of health outcomes in relation to vulnerable populations.¹

One way to incorporate a health into decision making is using a *Health Impact Assessment (HIA)*. HIAs is a tool and a process that helps evaluate the potential health effects of a plan, project, or policy before it is built or implemented (Box 14).⁶⁴ HIAs are used for single decisions and/or discrete projects and use data-driven and evidence-based quantitative, qualitative, and participatory assessments.¹⁴ Practitioners select issues to assess, define the parameters of the assessment, explore the health impacts of a future proposal, and provide information and recommendations to decision makers (check list of resources).¹⁴

Prince George's County incorporated HiAs as one of its core assessments to protect the health of its residents through a 2011 ordinance and maintained this requirement during its HiAP oriented county Zoning Rewrite, (Box 15).⁶⁵

Health Lens Analysis (HLA) is qualitative assessment tool used to advance HiAP.⁶⁶ HLA was designed specifically to be applied very early in the process of developing policy ideas in areas with a potentially large impact.

When the timeframe is short, *Health Notes* can be an alternative for HIAs. Health Notes is a rigorous, rapid, and impartial summary that uses available research. Health Notes can be developed in a short time (e.g. the legislative process) to provide evidence-based recommendations for decision-makers on the positive and negative effects of the intended policy. Health Notes consider the context of the legislation and include available local data to show the potential impact on specific groups of people, communities, and programs.⁶⁷



Box 14: Assessing Possible Impacts of Policies

Health Impact Assessment is a process that helps evaluate the potential health effects of a plan, project, or policy before it is built or implemented.⁶⁴

Health Lens Analysis is a process designed specifically to be applied very early in the process of developing policy ideas in areas with a potentially large impact.⁶⁶

Box 15: HiAP in Maryland

Prince George's County

The Path to a HiAP-driven Zoning Ordinance Rewrite

2011 Ordinances CB-29-2011 and CB-41-2011 were approved by the County's Council

REQUIREMENTS

- ✓ The County Health Department to conduct HIAs for specific new developments
- ✓ The planning board to refer site, design, and master plan proposals to the Prince George's County Health Department for a HIA

Formula 2040

Prince George's County Council adopted Formula 2040. This framework for Parks and Recreation programmatic and facility needs specifically addressed making changes to the Zoning Ordinance and Subdivision Regulations. Developing urban parks provide recreational opportunities and thereby improve the health of the County's residents.

2013



Functional Master Plan for Parks, Recreation and Open Space in Prince George's County

PLAN 2035
PRINCE GEORGE'S

2014 Plan Prince George's 2035

Prioritized an update to the fifty-year-old County's Zoning Ordinance and Subdivision Regulations as a critical step for the County's growth, economic development and improved quality of life for residents

KEY HEALTH CONCERNS

Improve access to healthy food and favor the adoption of better levels of daily physical activity.

RECOMMENDATIONS

- ✓ Integrate community health into the master plan and development review processes
- ✓ Improve residents' access to fresh foods, in particular for households living in low-income areas with limited transportation options, and promote sources of fresh foods countywide
- ✓ Educate and build awareness of health and wellness initiatives that prevent and control chronic disease.
- ✓ Improve access to health services and programs

2018

HiAP-driven Zoning Ordinance Rewrite Approved



The four-year-long process had massive public participation. Its HiAP-driven nature led to the inclusion of several items that aim to address the SDoH and further the adoption of a HiAP's collaborative approach for future developments.

- ✓ Collaboration and public participation: Around 350 stakeholder meetings, community-based input forums, comments by letter, e-mail or CivComment
- ✓ HIA was further incorporated and required detailed site plans, the general plan, functional master plans, area master plans, and sector plans be referred to the Prince George's County Health Department to review the project for the potential health impacts on neighboring communities
- ✓ Increased street and sidewalk connectivity help improve access for walking
- ✓ Community gardens and urban farms are permitted in more zones
- ✓ Increased flexibility for grocery stores and other healthy food retailers to allow for the expansion of healthy food outlets within the County
- ✓ Mandatory industrial form and design standards, in combination with neighborhood compatibility standards, help protect residential neighborhoods from new and expanding industrial uses



More than 200 project-specific HIAs were developed from 2011 to 2017, along with one complete HIA and one partial HIA for master plans.

Sources:

⁶⁵ Prince George's County Planning Department. *Health and Zoning in Prince's George County*; 2016:17. <http://zoningpgc.pgplanning.com/wp-content/uploads/2015/04/Health-and-Zoning-7-19-16.pdf>.
⁶⁸ Prince George's County Planning Department. *Consolidated Comments on Comprehensive Review Draft*; 2018. http://zoningpgc.pgplanning.com/wp-content/uploads/2015/04/Consolidated-Comments-and-Analysis-of-CRD_FINAL.pdf.
⁶⁹ Prince George's County Planning Department. *Prince George's Zoning Rewrite*. <http://zoningpgc.pgplanning.com/>

HiAP BEST PRACTICES

HiAP is a framework for public health practice¹⁵ and represents a shift from pursuing independent, topic-based and siloed interests towards a collaborative way to achieve shared goals.⁸ HiAP initiatives are new in the U.S context and there is still a need for more rigorous evidence.⁸

Currently published material shows that HiAP implementation requires creativity and innovation. Although there is no right way to implement HiAP, on-going initiatives have some common characteristics that include, but are not limited to: creating and sustaining partnerships, engaging stakeholders, identifying opportunities for change, strategic use of resources, and accountability structures.

A. Create and Sustain Partnerships

Cultivating partnerships cross agencies ensures that HiAP efforts can be coordinated and helps create buy-in for integrating health equity as a core value of every government agency.^{8,14} Relationships should include policymakers, federal/national partnerships, community organizations, residents and providers within communities, and the media.¹ One way to embed HiAP in current processes and create institutional backing to drive relationship building and support stakeholder engagement is to develop an institutional home for cross-sector collaborations, such as interagency councils or taskforces which may also (Box 16).⁸

Cross-agency partnerships may vary from sharing information all the way to collaborating on new projects or adopting shared goals, measures, and resources.¹ These types of relationships require a base of trust, mutuality, and reciprocity.^{1,11} A HiAP champion is someone with key relationships, high visibility, or organizational influence who uses his power to promote HiAP and gather support (Box 17).¹

Finding champions at partner organizations and committing to build trust is important to advance HiAP work.^{8,14} It takes time for partners to understand how working



Box 16: Maryland HiAP Council

The Maryland HiAP Workgroup recommended that a HiAP council be created to help implement and guide Maryland Health in All Policies activities. [Link](#)



Box 17: HiAP Champions

A **HiAP Champion** is someone with key relationships, high visibility, or organizational influence (such as a county supervisor, mayor, governor, agency director, or community leader), who uses their power to promote HiAP and gather the support of other players.¹ They help create the political will to support HiAP initiatives.¹⁴

together can benefit them. *Starting small with a well-defined framework* is a good way to set the path for broadening future cross-sector collaboration.^{8,14}

B. Engage Stakeholders

Community engagement is central to HiAP process. They can inform how problems should be prioritized and how government policies impact their communities' health.¹² Successful HiAP initiatives engage community members and stakeholders to "solicit their input, develop a vision of a healthy community, and identify and prioritize changes to policies and practices."^{23(pp18)} The increased incorporation of community engagement and social participation in HiAP helps to ensure fair decision-making on health equity issues.¹⁰

Creating healthy communities includes supporting them in finding opportunities to be healthy.¹¹ Beyond collecting community feedback, government agencies should be committed to developing authentic partnerships and shared decision-making at the community level. Communities and other partners also have the power to influence political will, which is usually cited as a barrier to HiAP.¹⁴

C. Identify Opportunities for Policy Change

HiAP engaged partners should select priorities and have the best possible understanding of the problems they intend to target in order to identify HiAP opportunities (Box 18). They should be equipped to inform with the best quality and most current data and to propose evidence-based and community-based solutions when opportunities arise.²⁵ HiAP initiatives should, if possible, align to issues of current political and social interest (e.g. climate change, obesity, opioid epidemic) because these issues have potential to gain traction and influence political will.¹⁹



Box 18: HiAP Opportunities¹²

- Councils, boards and commissions
- Programs and direct service
- Hiring, retention, promotion
- Data collection, analysis, reporting
- Regulation, ordinances, taxes, fees
- Planning: land use, transportation, housing, violence prevention, economic development

HiAP is more likely to be sustained when there is regulatory and legislative backing.^{70,71} Whenever possible, HiAP and equity should be written in mission statements of departments or in the state and counties health improvement plans.⁷² Changes in political leadership, public pressure, crises, and disasters can also be opportunities to advocate for and to formalize HiAP approach.^{11,72} Another successful strategy is having HiAP within federal, state, local, and organizational planning processes, budget assessment and other key documents/efforts to advance health equity as well as capitalizing on these opportunities.



Box 19: Health Equity Leadership

"When the organization work to expand the understanding of what creates health, the work acts as a foundation and catalyst for policy change; strong equity-focused leadership; innovative approaches around data collection and analysis; workforce development and continuous improvement; new and stronger partnerships; and more effective ways to organize resources to address SDoH and advance health equity."^{11(pp14)}

D. Strategic Use of Resources

Expanded knowledge on SDoH and equity will only turn into action for change if resources are leveraged to reflect commitment to health equity values.¹¹

Effective HiAP leadership, quality data and measurement tools, personnel and workforce development, and effective financial and human resource allocation are key to HiAP and to achieve health equity.¹¹

Leadership and workforce development

Champions, public health leadership, and frontline staff are all essential to HiAP.¹³ While champions help create the political will to support HiAP initiatives, leadership provides the vision and guides the implementation process.¹⁴ Health equity focused leadership should work to expand the understanding of what creates health (Box 19).¹¹

Leadership is cited as a core driver for involvement with HiAP.⁷² Strategies that lead to sustained structural change include leadership that encourages learning from successes and failures and a well-designed learning and improvement system that invests building personnel capacity at all levels.

Three successful leadership strategies to promote (structural) change are¹¹:

- a) championing learning at all levels of an organization to increase capacity and motivation to improve system performance.
- b) incorporate learning through training, peers support and sharing of lessons learned
- c) structured method to make improvements and spread good ideas.

HiAP backbone staff

Ideally, HiAP should have dedicated staff to maintain relationships, facilitate meetings, write reports, and collect data.¹⁴ However, training a diverse group in HiAP (e.g., health educators, program managers, policy analysts, planners, etc.) can also be successful.

Recruiting and retaining HiAP staff can be challenging due to constant changes in leadership, policies, job dissatisfaction, etc.^{12,72} Loss of key personnel may jeopardize the HiAP process, which is built on established relationships; thus, planning for staff turnover leadership changes is important for sustainability.

Data-driven policy and health information

Information on health problems and on the impacts that projects or policies can have on health are vital evidence to inspire the political will to support or refrain from supporting policies and projects.¹⁴ Collecting, analyzing, and sharing data allow for all stakeholders to be informed with updated and relevant information.¹⁴


Leaders must support equity-focused data collection and analysis while also using data to inform leadership activities.¹¹ Informational resources, along with information on links between health and other sectors, promising policies, and best practices, can be used to both advance public health work and continue to educate leadership to build and maintain buy-in for HiAP.^{14,23}

Also important is that partners may expect that public health can quantify health issues or impacts, which is usually a challenge among those implementing HiAP.^{8,72} There is need to develop a culture of data-driven information in which methods of data collection and analysis must align with, as well as inform, the understanding of what determines health and equity.^{11,72} The Maryland HiAP workgroup proposed a process to sharing data among state agencies (Box 19).

Available local level data may be a barrier, but focus groups and survey data can also inform decision making.¹⁴ Partnering with universities and/or public health institutes



Box 20: Fostering collaboration through data sharing

The Maryland HiAP workgroup created a process to guide state and county agencies to facilitate data sharing between and within agencies . Sharing data is essential to guarantee that policies and programs are informed with updated and quality data.

may be a way to address the shortage of local data as well as to get help with technical expertise and facilitation of other processes.⁷² Additionally, HIAs and HLAs can provide processes for analyzing data, making recommendations, and engaging decisionmakers.¹⁴


Financial resources, funding and investments

Through collaboration, government sectors can identify areas of common interest for investment, which reduces waste and promotes spending efficiency.¹⁴ Still, a lack of funding has been consistently cited as the biggest challenge to implementing HiAP initiatives.^{8,72} Successful efforts have sought out external funding or negotiated to obtain resources dedicated to HiAP.¹⁴ There are several innovative approaches to financing, including grants and consulting payments.

Another way of strategically use resources for HiAP is through the use of procurement processes. Score funding applications that weight the inclusion of health objectives on funding and investments announcements is a way to incentive the institutionalization of HiAP.⁹ The Maryland HiAP Workgroup recommended that applicants be credited in the procurement scoring process based on their business practices and HiAP oriented decision-making (Box 21).



Box 21: HiAP and funding proposals.

The Maryland HiAP Workgroup recommended that that applicants receive additional credit in the procurement scoring process based upon their articulated business practices and decision-making that support HiAP. 

E. Accountability: Tracking Outcomes, Evaluating Impacts and Communicating Progress

There are many challenges to measuring and evaluating changes in policies (HiAP included) and systems changes.^{73,74} Thus, a well-designed improvement system that incorporate evaluation is crucial to success in achieving structural change.¹¹ Evaluating the effects of a project or/and policy initiative also is a great way to identify areas for improvement, communicate success, and create buy-in for continued work.^{8,12}

Before implementing HiAP, an evaluation plan with short- and long-term goals and measurable outcomes should be clearly defined.^{12,13} An evaluation plan boosts transparency and help to assure that HiAP partners have a clear understanding of what success look like. An evaluation plan also help to ensure robust data collection that is likely to inform funders and stakeholders of the initiative's impact.¹² In order to know if there is progress towards shared HiAP, it is crucial to understand how to measure systems change and changes in health outcomes.⁸

Formal evaluation includes process and outcome evaluation.¹² While *process evaluation* aid on the development of effective engagement/collaboration such as the number of partners engaged and number of participants in a project, *outcomes evaluation* serves to monitor changes in SDoH such as changes in healthy community infrastructure investments and changes in chronic disease rates related to issue-specific projects.

There are inherent difficulties in understanding how HiAP affects people's health because it is difficult to attribute any changes in health outcomes to a policy.^{8,72} There are also challenges in showing value to HiAP objectives such as building partnerships or engaging communities. These challenges have been reported as a barrier to create and maintain support for HiAP.⁸ Partnering with academic researchers can provide valuable technical support and

credibility to HiAP efforts through data analysis and evaluation processes.¹² Some creative evaluation initiatives include tracking the number of cross sector collaborations, tracking the level of collaboration among cross sector partners over a specified time period, or tracking requests for technical assistance from cross sector agencies.⁸

Good evaluation practices include developing or adopting indicators and rating systems to monitor healthy community development.¹² Reported HiAP impacts include the implementation of (or willingness to implement) shared metrics across agencies or a shared agency dashboard that tracks health outcomes.⁷²

Other accountability mechanisms include communicate progress through public reporting, performance measures that include health considerations, budget oversight, and monitoring and enforcing laws that might affect health.⁹

Conclusion

HiAP is a way of embedding health, equity and sustainability into decision-making and create s At its core it is an approach to addressing SDoH and promote equity. In the U.S context, HiAP is an innovative and new practice and it requires that the buildup of partnerships across sectors and policy areas to shift current policies practices into collaborative approaches to achieve shared goals and improve the health of the population.

There is not any right way to implement a HiAP approach because of the different contexts in which communities are immersed. HiAP initiatives are flexible, developed within political and community contexts, and address specific communities' needs.

This guide brings concepts, practices and examples of promising HiAP practices and was created as a resource to support initial implementation of HiAP into decision making processes across Maryland state agencies and departments.

RESOURCES

Click on the underlined areas to see the resources on the web. Resources are also listed in the references.

HiAP Toolkits

- APHA | [Health in All Policies: A Guide for State and Local Governments](#)¹
- ASTHO | [HiAP framework](#)⁷⁵
- CDC | [Health in All Policies Resource Center](#)⁷⁶
- ChangeLab Solutions | [From Start to Finish: Health in All Policies: how to permanently improve government](#)²³
- Kent County | [HiAP WebToolkit](#)⁷⁷
- NACCHO | [HiAP Resource Page with webinars, tools, legislation track and other resources](#)⁷⁸
- WHO | [Health in all policies training manual](#)⁷⁹

Health Impact Assessment and other Planning Tools

- CDC | [Healthy Community Design Checklist and Toolkit](#)⁸⁰
- Maryland Department of Health | [Maryland HIA Toolkit](#)⁸¹
- NACCHO | [Health Impact Assessment Project](#)⁸²
- The Pew Charitable Trusts | [Health Impact Project](#)⁸³
- WHO | [Concepts, examples, methods and use of HIA in policy](#)⁸⁴

Health Equity Analysis

- Ministry of Health and Long-Term Care - Ontario | [Health Equity Impact Assessment Tool](#) (workbook and template)⁸⁵
- Tacoma-Pierce County Health Department, Washington | [Health Lens Analysis Tool](#)⁸⁶

Health Equity Resources

- APHA | [Health Equity Resources Page](#)⁸⁷
- CDC | [Health Equity \(Obesity and Disparities\) Toolkit](#)⁸⁸
- CDC | [Health Equity Page](#)⁸⁹
- ChangeLab Solutions | [Blueprint for Changemakers - Achieving health equity through law & policy](#)⁹⁰
- ChangeLab Solutions | [Building Healthy, Equitable Communities](#)⁹¹
- ChangeLab Solutions | [Good Governance Building health equity into governance](#)⁹²
- Coalition of Communities of Color | [Tool for Organizational Self-Assessment Related to Racial Equity](#)⁹³
- HRSA & Region V Collaborative Improvement and Innovation Network (ASTHO's website) | [Foundational practices for health equity](#)¹¹
- King County | [Equity and Social Justice Initiative](#)⁹⁴
- Maryland Department of Health | [Maryland Health Equity Data](#)⁵⁹
- National Collaborative for Health Equity (CHE)⁹⁵
- Racial Equity Tools | [Resources Website](#)⁹⁶
- Seattle Office of Civil Rights | [Racial Health Equity Toolkit](#)⁹⁷
- The Center for Global Policy Solutions | [Allies for Reaching Community Health Equity initiative](#)⁹⁸

Health Literacy

CDC | [What is Health Literacy?](#)⁹⁹

Social Determinants of Health Resources and Initiatives

Health Affairs | [The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities](#)¹⁰⁰

HHS Office of Minority Health (OMH) | National Partnership for Action to End Health Disparities | [Compendium of Publicly Available Datasets and Other Data-Related Resources](#)¹⁰¹

Maryland Department of Health | [Health Enterprise Zones](#)¹⁰²

Maryland State Health Improvement Process | [SHIP Measures \(local data\)](#)¹⁰³

United States Department of Agriculture (USDA) | [Food Environment Atlas](#)¹⁰⁴

University of Wisconsin School of Public Health | [The Neighborhood Atlas](#)¹⁰⁵

USDA | [Food Access Atlas](#)¹⁰⁶

Maryland HiAP Workgroup Resources

Maryland Center for Health Equity | [HiAP Workgroup page](#)¹⁰⁷

General Assembly Report | [January 2018 report](#)¹⁰⁸

General Assembly Report | [January 2019 report](#)¹⁰⁹

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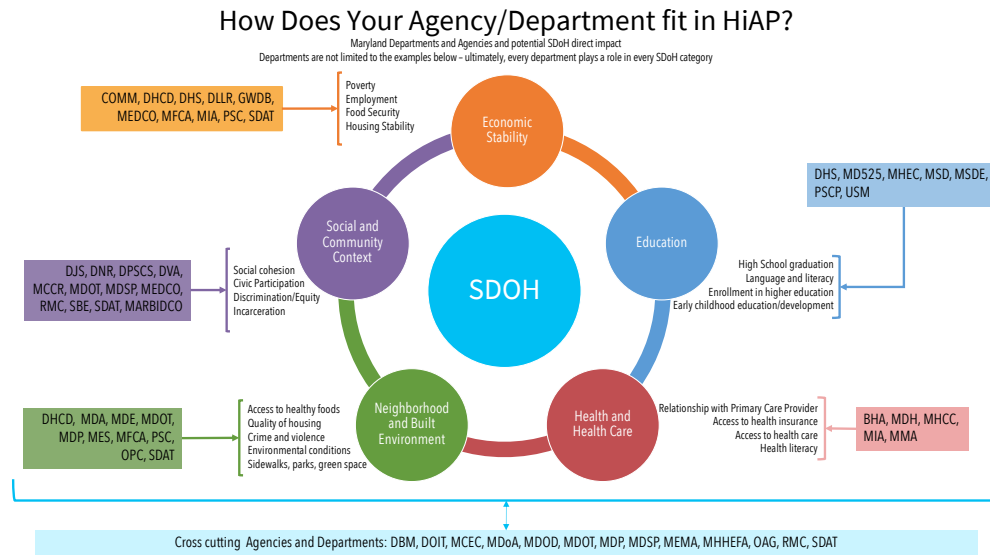
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APPENDIX

Figure 03 - Maryland agencies and departments by policy area and SDoH domain.



List of acronyms:

Behavioral Health Administration	BHA
Department of Commerce	COMM
Department of Housing and Community Development	DHCD
Department of Human Services	DHS
Department of Juvenile Services	DJS
Department of Labor, Licensing, and Regulation	DLLR
Department of Natural Resources	DNR
Department of Public Safety & Correctional Services	DPSCS
Department of Transportation	MDOT
Department of Veteran Affairs	DVA
Governor's Workforce Development Board	GWDB
Interagency Committee for School Construction	PSCP
Maryland 526	MD525
Maryland Agriculture & Resource-Based Industry Development Corporation	MARBIDCO
Maryland Clean Energy Center	MCEC
Maryland Department of Aging	MDoA
Maryland Department of Agriculture	MDA
Maryland Department of Budget and Management	DBM
Maryland Department of Disabilities	MDOD
Maryland Department of Health	MDH
Maryland Department of Information Technology	DOIT
Maryland Department of Planning	MDP

Maryland Department of Planning	MDP
Maryland Department of the Environment	MDE
Maryland Department of Transportation	MDOT
Maryland Economic Development Corporation	MEDCO
Maryland Emergency Management Agency	MEMA
Maryland Environmental Service	MES
Maryland Food Center Authority	MFCA
Maryland Health and Higher Educational Facilities Authority	MHHEFA
Maryland Health Care Commission	MHCC
Maryland Insurance Administration	MIA
Maryland Medicaid Administration	MMA
Maryland Office of People's Counsel	OPC
Maryland School for the Deaf	MSD
Maryland State Police	MDSP
Maryland's Public System of Higher Education	USM
MD Higher Education Commission	MHEC
MD Public Services Commission	PSC
Office of the Attorney General	OAG
Rural Maryland Council	RMC
State Board of Elections	SBE
State Department of Assessments & Taxation	SDAT
State Department of Education	MSDE
State of Maryland Commission on Civil Rights	MCCR

Appendix VII: Team F Optional Procurement Document

The attached addendum provides a template for how to integrate HiAP principles into procurement opportunities. This addendum is designed to be optional for vendors responding to procurement opportunities, and can provide a starting point to the new HiAP council for adaptation and implementation.

The Association of State and Territorial Health Officials (ASTHO) defines HiAP “as a collaborative approach that integrates and articulates health considerations into policymaking across sectors, and all levels, to improve the health of all communities and people.” As purchasing agents of the State of Maryland, agencies are allowed to use information on an applicant’s strategies that improves health and health equity to make determinations on funding awards. This optional worksheet permits applicants to receive additional credit in the procurement scoring process based upon their articulated business practices, decision-making, and potential “value added” to health and health outcomes for their employees and the general population.

The Health in All Policies Council has developed a Framework and Toolkit to serve as a guide for organizations seeking to do business with the state. The Framework is based on the U.S. Centers for Disease Control and Prevention’s Policy Process Framework which was developed as part of the National Prevention Strategy in 2014 and can be updated and adapted by the HiAP Council to suit the needs of the state of Maryland. It outlines the main policy steps at which HiAP principles can be engaged, while the Toolkit can be used to develop employee training, engage in strategic planning, and enact steps that can directly and/or indirectly lead to positive health outcomes for their workers, customers, Maryland residents, and the general population as a whole. The Framework and Toolkit can be accessed [HERE](#).

Please complete the following checklist so that we can better understand your practices as they relate to health.

THE CHECKLIST BELOW SHOULD BE DEVELOPED BY THE FRAMEWORK ADOPTED BY THE HiAP COUNCIL, IT COULD INCLUDE TRANSPORTATION, ENERGY, FOOD JUSTICE, FAITH-BASED, PUBLIC SAFETY, HOUSING, OR OTHER RELEVANT ACTIVITIES THAT INFLUENCE HEALTH:

	Checklist Item	Description
<input type="checkbox"/>	Has your organization implemented an evidence-based program focused on worker safety, tobacco use, or other prevention activities?	If yes, please describe
<input type="checkbox"/>	Is your organization a participant in the Healthiest Maryland Business (HMB) program and have you completed the CDC Prevention Scorecard?	If yes, please describe
<i>This is not an exhaustive list, is not final, and principles will be developed by the HiAP Council</i>		

Appendix VIII: Team D Data Sharing Process Document

Background

In January 2018, the first Maryland Health in All Policies (HiAP) Report was provided to the General Assembly as mandated by 2017's Senate Bill 340 and House Bill 1225. Five initial recommendations identified by the HiAP Workgroup were presented in the report, one of which related to creating a process to facilitate both health and non-health data sharing. Specifically, this recommendation (#4) stated:

“The workgroup recommends that a process to provide guidance to state and county agencies to facilitate data sharing, between and within agencies, be developed to ensure health and non-health data are being shared to support health in all policies. Appropriate, efficient data sharing is crucial in developing policies that best address the needs of residents of the State. The workgroup recommends providing county and state agencies with templates of materials, such as Memorandums of Understanding and Data Use Agreements to support agreements between agencies and provide guidance to agencies about how and why it is important to share data to address health problems. Additionally, the workgroup recommends that initially, this process may focus on publicly available data from population survey sources including, but not limited to, the Maryland Behavioral Risk Factor Surveillance System. The workgroup recommends that the process would begin in 2018 as a pilot data sharing activity within the membership of the SB340 Workgroup.”

Introduction

This document presents the recommendation for creating a process to provide guidance to state and county agencies that facilitates data sharing, both health and non-health data between and within agencies, to support health in all policies. A data-sharing pilot was not undertaken at this time, because there was group consensus that larger systemic barriers at the agency level for data sharing must be addressed before any pilot study could yield meaningful new information. In other words, pilot studies are most valuable when conducted within or between agencies that value data sharing and have developed internal support structures and feedback loops to improve related processes.

In fulfilling its charge, the workgroup developed a process to facilitate data sharing that takes into account efficiency, effectiveness, and the implications of making decisions that improve population health and health equity. The workgroup wanted to ensure that whenever a new project, program or policy is being developed, the interests of the affected population(s), as well as human health considerations, environmental impacts and foreseeable outcomes are considered during their formulation. The workgroup considered the need for building support structures and the capacity for data sharing, while at the same time ensuring data protection and security. The process to facilitate the inclusion of community concerns and questions, and data sharing (**Figure 1**), explanation of each step, and questions that agencies should consider at each step of the process are included below. This is followed by recommendations of the workgroup.

Figure 1: Process to Facilitate Data Sharing within a Health in All Policies Framework



Step 1: ESTABLISH HEALTH AND HEALTH EQUITY GOALS

ESTABLISH HEALTH AND HEALTH EQUITY GOALS AND DESIRED OUTCOMES OF YOUR PROJECT/PROGRAM/POLICY

Clarity on the goals/vision will guide the development for why data sharing is important, inform what structures need to be in place, and focus on what data needs to be shared e.g., equity measures, health indicators. etc. As shown in **Figure 1**, always consider the stakeholder and community engagement aspect of any task, project or product under consideration by the agency at every step of the process. While government agencies have some data that can be used to generate ideas about what may be going on in a community, that data must be complemented with local needs, priorities, data, information and input from community members.

In order to bring a health and health equity lens into all policies, agencies must require that a consideration of health impacts be brought into the earliest stages of new project, program or policy formulation. Transportation, housing, health care, employment, environmental quality, environmental hazards, working conditions, education, child care, law enforcement—all of these sectors and others have a role in creating the conditions that enable all people and communities to attain and sustain good health. The connections of new programs or policies to health outcomes need to be explored and evaluated to avoid unintended health consequences.

Project goals should include outcomes to improve health especially for vulnerable populations (health equity model). Look beyond overall health outcomes at how health varies between population groups within a jurisdiction, such as a county or community. Look beyond individual behavior at social and economic conditions, investments and outlooks that impact health. Consistent health goals and messaging should be encouraged across disciplines. Agencies need to know what questions they want to answer before they can determine what data are needed. Agencies must also examine if the data they are collecting can accurately provide public health experts with the data necessary to monitor impacts of toxic exposures or known hazards so that actions can be taken to better protect public health.

Finally, being aware of larger statistical information (such as national data collected by CDC, EPA, USGS, etc.) can help focus data priorities on predominant chronic and acute health risks, as well as ensuring positive environmental impacts.

WHAT ARE OUR GOALS?

- ✓ What health indicators and health equity factors should drive what data sources we use? *(Develop performance indicators. Helpful resource may be an epidemiologist.)*

WHAT ARE THE ISSUES? (Look at Health Indicators)

- ✓ What are the stakeholders' health, environmental, equity challenges in their communities?
- ✓ What are the known public health indicators that may be affected by your project, program or policy?

- ✓ Does your data collection adequately provide for scientifically valid public health monitoring? Is it based on a scientifically valid sample? Does it provide the necessary details for needed monitoring such as annual data and data based on zip codes?
- ✓ What populations or demographics will be affected by your project, policy or program?
- ✓ What is the condition and type of environmental media impacted by your project, program, or policy?
- ✓ How can these data be shared without violating privacy?

WHO ARE THE STAKEHOLDERS IMPACTED BY YOUR PROJECT?

- ✓ Who will be affected by the proposed solution, and will different groups be affected differently?

WILL THE DATA SHARING PROCESS REDUCE INEQUITIES? *In order to address social disparities, promote a health equity framework for data sharing.*

- ✓ Are there subpopulations where inequities have existed in the past?
- ✓ Are there new or existing population groups that have not been accounted for?
- ✓ What data are necessary to tease out those inequities?
- ✓ Is the data collected regularly (e.g., annually, biannually, etc.) in order to assess changes and new unforeseen inputs?
- ✓ What impact will the data-sharing process have on subgroups, vulnerable or under-resourced groups and communities of a population, and on specific geographic regions?

HOW AND WHEN WILL THE INFORMATION BE USED?

Please think thoroughly through this question.

Step 2: REINFORCE NEED FOR DATA SHARING

REINFORCE THE NEED FOR DATA SHARING BETWEEN AND WITHIN AGENCIES

Buy-in from staff within and across agencies that data sharing will lead to better public health and environmental outcomes, as well as improved agency operations, is essential to the success of data sharing efforts. This can only happen when leadership within and between agencies reinforce and communicate the needs, goals, and co-benefits of a data-sharing culture. Leaders must understand and be able to communicate to staff the answers to the following questions:

- ✓ Why do we need data sharing?
- ✓ What are our goals? *(Project goals should include outcomes to improve health, especially for vulnerable populations [health equity model]. Look not only at overall health outcomes but also at how health varies between population groups within a jurisdiction, such as a county. Look at individual behavior, as well as at social and economic conditions that impact health. Consistent health goals and messaging should be encouraged across disciplines. Agencies need to know what questions they want to answer before they can determine what data are needed.)*
- ✓ How will data sharing help reduce redundancy, save money, and increase effectiveness, especially in cases where multiple partners need the same information? *(For example, transportation agencies could consider broadening the scope of their data collection efforts to include assessment of transportation access to health clinics, parks, and other health-promoting sites.)*
- ✓ Will the benefits of sharing of these data outweigh the risks to privacy that follow from sharing?
- ✓ How will data sharing improve our environment, services and government efficiency?
- ✓ Will sharing data and aligning other processes simplify determining eligibility and enrollment in social and health services?
- ✓ Will data sharing establish a collaborative approach to improving population health?
- ✓ Will data sharing encourage cross-sectional partnering to address social determinants of health? *(It is important to recognize the relationship between health in all policies and health equity.)*
- ✓ How will the agencies (or other entities) involved ensure that the privacy of individuals is protected?

Step 3: BUILD SUPPORTING STRUCTURES AND PROCESSES

ASSESS CURRENT DATA- SHARING PROCESSES (*What is the current Data- Sharing process?*)

Being aware of larger statistical information (such as national data collected by CDC, EPA, USGS, etc.) can help focus data priorities on predominant chronic and acute health risks, as well as ensuring positive environmental impacts. There are other models if data sharing is needed relative to programs and strategic processes that address health equity. Given health care transformation, there are a lot of new data sharing and integration processes that will come into play. A discussion of how those new processes can assist with the HiAP goals is important and should be considered.

For example, health equity is an important aspect of the new Total Cost of Care (TCOC) All-Payer model. This model needs to be assessed for how the TCOC and new health transformation goals will affect recommendations. Social determinants of health is a major aspect of this model implementation for data sharing and will require cross sector work. The effort around data sharing is much of what the HiAP is about.

BUILD SUPPORTING STRUCTURES AND PROCESSES FOR DATA SHARING

Institutionalizing supportive structures for data sharing is critical to make data sharing possible within or across agencies. One way to accomplish this is to create an administrative, communication and accountability framework within and across institutions to ensure data sharing and related issues are routinely discussed and tracked. Creating a multidisciplinary data-sharing taskforce responsible for implementing this administrative and accountability framework within the organization, as well as for leading overall implementation of the action plan and reporting to the highest organizational levels, will ensure success.

Developing or adopting specific templates, such as data sharing agreements, can also provide supportive structures for sharing data. Further developing state data centers and clearinghouses, websites for data sharing, or other mechanisms to provide easy data access can also help break down silos and provide supportive structures. Lastly, capacity building within and across organizations is paramount to fostering an ongoing data-sharing culture.

At the same time that these larger within and cross-agency structures are being institutionalized, a smaller-scale process must also be institutionalized whereby positive health impact and health equity, along with positive environmental impact considerations, are brought into any project, program or policy formulation process. It is worth stating that data sharing can also highlight applications needing to be addressed in data collection (e.g., data gaps and/or missing data necessary to monitor health impacts, etc.).

WHAT TYPE OF DATA-SHARING AGREEMENT IS NEEDED (FORMAL? STRUCTURED?)?

Develop a template of Memorandums of Understanding [MOU] and Data Use Agreements (by Legal team and Institutional Review Board [IRB]). Focus on Publicly available data (e.g., CDC's Environmental Health Tracking Network).

ARE RELEVANT QUANTITATIVE AND QUALITATIVE DATA AVAILABLE AND ACCESSIBLE?

✓ What is our inventory of data?

Expand the inventory of data (by key groupings - free data, right to know.... Risk data, mapping data) obtained by various agencies including but not limited to:

- *State Agencies and Commissions*
 - *Maryland Department of Health*
 - *Maryland Health Care Commission*
 - *Maryland Health Services Cost Review Commission*
 - *Maryland Department of Agriculture*
 - *Maryland Department of Environment*
 - *Maryland Department of Natural Resources*
 - *Maryland State Department of Education*
 - *Maryland Department of Transportation*
 - *Maryland Department of Planning*
 - *etc.*

- *National Data*
 - *CMS (U.S. Centers for Medicare & Medicaid Services)*
 - *EPA (U.S. Environmental Protection Agency)*
 - *CDC (U.S. Centers for Disease Control and Prevention)*
 - *NIH (U.S. National Institutes of Health)*
 - *NIEHS (National Institute of Environmental Health Sciences)*
 - *U.S. Census Bureau*
 - *USGS (U.S. Geological Survey)*
 - *etc.*

- *Other State and County Data:*
 - *Education*
 - *Transportation*
 - *Environmental*
 - *Housing*
 - *Maryland Behavioral Risk Factor Surveillance*
 - *Planning*
 - *Zoning*
 - *Other infrastructure data as appropriate*

Step 4: CREATE ACTION PLAN FOR DATA SHARING

CREATE AN ACTION PLAN FOR DATA SHARING

With data selected, developing the action plan can have objectives that focus on the data stewards, templates and examples will facilitate sharing, the qualities of the data sources/sets and incorporate what the limitations and conditions are for those data and if proxies can be found or rules and protections set up for those data. Data selection will also determine what resources (funding, expertise, training, staff, technology) are needed to make the sharing happen prior to actually sharing the data.

Once health and health equity goals have been established, an action plan can be developed to identify strategies and next steps for making key datasets available within and across agencies. Action plans should identify specific deliverables and timeframes for addressing data priorities, and any staff responsible for those efforts. Action plans should also consider barriers or other institutional obstacles to data sharing, particularly handling HIPAA, confidential or personally identifiable information.

IS IT POSSIBLE TO IMPLEMENT THE PROPOSED SOLUTION?

Begin strategic planning and prioritization. Examine feasibility of strategies for data sharing.

Feasibility: In some ways, feasibility is a combination of many of these criteria. Often it is a proxy for resources, jurisdiction, and support from decision-makers. Feasibility must encompass the costs of action but must also include an analysis of the costs of inaction for vulnerable populations.

WHAT RESOURCES ARE AVAILABLE TO YOU?

- ✓ Will state-level or county-level data be sufficient? (*The needed levels may differ depending on how the data will be used*).
- ✓ What steps have partner agencies taken to impart health, equity, and sustainability knowledge to their staff?
- ✓ Are resources available for primary data collection, such as surveys, interviews or focus groups?

DOES THE PROPOSED DATA-SHARING PROCESS REQUIRE ACTION AT THE STATE LEVEL, OR IS THERE ALSO A ROLE FOR LOCAL (OR FEDERAL) JURISDICTIONS?

- ✓ Who has the authority to take action—including regulation, guidance, funding, and convening?

Step 5: REVIEW THE TERMS AND CONDITIONS FOR DATA SHARING

REVIEW THE TERMS AND CONDITIONS FOR DATA SHARING

One of the greatest priorities is to safeguard data: to ensure the privacy of individuals, to protect confidentiality, and preserve the value of proprietary data. Once you have an action plan and know what health-related and/or environmental data are needed for your project, you can determine which datasets require safeguards. Agencies should employ ‘need to know’ principles, meaning that, when sharing both internally between departments and externally with other organizations, individuals should only have access to certain data if they need it to do their job, and only relevant staff should have access to the data. Important questions to consider during this process include:

- ✓ Does the data-sharing process safeguard the privacy of consumers and protect confidential and proprietary data?
- ✓ Will the data be secure?
- ✓ What information needs to be shared?
- ✓ Who requires access to the shared personal data?
- ✓ How are individuals made aware of the information sharing? (*Consider what to tell the individuals concerned.*)
- ✓ Is their consent needed?
- ✓ Do they have an opportunity to object? How do you take account of their objections?
- ✓ How do you ensure the individual’s rights are respected?
- ✓ What risk to the individual and/or the organization does the data sharing pose?
- ✓ When should it be shared?
- ✓ How should it be shared?
- ✓ What are the barriers to data sharing?
- ✓ Are the data accurate? (*Cross reference across federal, county and local study as a rule.*)

Step 6: EVALUATION

EVALUATE DATA SHARING OUTCOMES

A process of continuous evaluation, improvement, and adaptive management on data sharing and incorporating a health lens into policy or programs should be established. This continuous improvement process will help identify remaining institutional barriers and data needs/gaps.

Consideration must be given to analysis and resources necessary for next steps. Once the data is being shared, is there capacity for interpretation, identifying trends and patterns, will there be guidance or recommendations, and how will your agency communicate and collaborate to address what is discovered through data sharing? How will this be done with community input?

How will results be used—will there be changes and improvements based on evaluation findings?

This is an area where pilot studies can be developed to address identified needs and feedback loops established to answer such questions as:

WHAT WORKS AND WHAT DOES NOT WORK?

- ✓ Has participation led to increased trust among impacted stakeholder communities, partner organizations and agencies?
- ✓ Has participation led to a perceived or measurable increase in collaboration across sectors?
- ✓ How do partner agencies see the relationship between health, equity, sustainability, and their own agency objectives?
- ✓ Systems change. Will the proposed solution lead to the institutionalization of Health in All Policies efforts or embed health into decision-making?

HOW WILL FINDINGS BE DISSEMINATED?

- ✓ Will the findings be shared with the public? (*Community Advisory Board or other supported community based entity consisting of impacted or reasonably potentially impacted members.*)
- ✓ How can community members help you interpret the data?

STEP 7: BUILD CAPACITY FOR DATA SHARING

Creating dedicated budgets and positions as well as implementing training and mentoring programs (both ongoing and for new hires) will build the resource and knowledge base for data sharing. Other tools for building capacity, like implementing adaptive management or continuous improvement methods and leadership development programs, will build and sustain a data sharing culture.

HOW DO WE ALIGN PROGRAMS AND RESOURCES WITH ORGANIZATIONAL COMMITMENT TO DATA SHARING AND HEALTH EQUITY?

Example: Department of Budget Management will give funding preference to agencies with data-sharing agreements.

HAVE HEALTH, EQUITY, AND SUSTAINABILITY CRITERIA BEEN INCORPORATED INTO FUNDING OR PROGRAM EVALUATION CRITERIA OF PARTNERS OUTSIDE PUBLIC HEALTH?

HOW HAVE HEALTH, EQUITY, AND SUSTAINABILITY EXPLICITLY BEEN INCORPORATED INTO GOVERNMENT GUIDANCE OR POLICY DOCUMENTS?

- ✓ Have there been legislative actions to support use of a health and equity lens in decision-making?

HOW CAN WE TRAIN OR SUPPORT HEALTH PROFESSIONALS IN ACQUIRING SKILLS FOR DATA MANAGEMENT AND SHARING? (provide technical assistance).

- ✓ Continue to reinforce the HiAP Framework for data sharing and relationship between HiAP and health equity.
- ✓ Build knowledge and capabilities across the health care system to support transitions of care and continuity of service.
- ✓ Engage populations that experience health inequities in the assessment process.

WHAT OTHER USES OF TECHNOLOGY ARE AVAILABLE THAT FACILITATE DATA SHARING?

(Include online applications, document imaging, electronic recordkeeping, enhanced record retrieval, and call centers.)

RECOMMENDATIONS FOR DATA SHARING:

- **Create a task force responsible for implementing and evaluating the above health data sharing framework in State agencies.** This could be a workgroup within the proposed HiAP Council or Commission. Its members should include stakeholders and impacted community members as well as those with expertise in IT (Information Technology), ethics, study design, data security, data use agreements, and epidemiology.

Recommendations for the Taskforce: *Specific to facilitating data sharing between and within agencies:*

- Choose a policy pilot project to test how successfully the proposed approach is incorporating health considerations into decision-making and policy direction.
- Assess data collected by various agencies. Expand the data clearinghouse and make data more readily available to various agencies.
- Scan the data that is being collected to look for areas of overlap, and to see if there are ways of collecting data more efficiently and effectively.
- The Health in All Policies Taskforce should spearhead the development of data access initiatives and identify ways to piggyback data collection efforts across agencies.
- Incorporate human health metrics into program and policy implementation.
- Use equity-focused measures. Require stratification by variables that are already being collected (race, ethnicity, gender, age, zip code, census tract). Consider additional stratification variables including, (status as an environmental justice or traditionally underserved community, sexual orientation, gender identify, disability, low income subsidy, and language).
- The Taskforce should address the security and privacy surrounding the transmission or accessing of data and establish common rules for its security and privacy.
- Recommendation of what health indicators (asthma, obesity, etc.) and health equity (income, education, proximity to pollution, or environmental degradation, etc.) factors should be the priorities for MD's Health in All Policies.
- Develop an accessible and transparent template of MOU and Data Use Agreements.

RESOURCES ON THE BENEFITS OF DATA SHARING:

Disclaimer: Please note that these are not recommendations, simply items reviewed by the workgroup during the creation of this document.

GUIDE: NIH Data Sharing Policy and Implementation Guidance

National Institutes of Health Office of Extramural Research. (2003). *NIH Data Sharing Policy and Implementation Guidance*. Retrieved from

https://grants.nih.gov/grants/policy/data_sharing/data_sharing_guidance.htm#goals

This guidance provides the National Institutes of Health (NIH) policy statement on data sharing and additional information on the implementation of this policy.

ARTICLE: The Hilltop Institute - Overcoming Interagency Data Sharing Barriers

Idala, D.A., Somerville, M.H., Spicer, L.A., Boddie-Willis, C.L., John, J.L., and Roddy, T. (2011). Overcoming Interagency Data-Sharing Barriers: Lessons from the Maryland Kids First Act. *The Hilltop Institute*. Retrieved from

<https://www.scribd.com/document/287534159/Maryland-Data-Sharing-Brief>

ARTICLE: Maryland builds cross-department cloud for data sharing

By Sara Friedman, Sep 28, 2017

Friedman, S. (2017). Maryland builds cross-department cloud for data sharing. GCN. Retrieved from <https://gen.com/articles/2017/09/28/maryland-cross-department-cloud.aspx>

ARTICLE: State's \$200M MD THINK program to bring data analytics to social services

By Stephen Babcock, Mar. 10, 2017

<https://technical.ly/baltimore/2017/03/10/hogan-md-think-social-services-data/>

MD THINK allows employees to only view data specific to their needs. The goal is to be able to share information among various agency silos, but put it into through a “highly segregated” platform with security controls to limit the amount of sharing of unnecessary details. The platform was initially conceived to include health benefits data from the Department of Health as well, but the work has been scaled back to the two agencies with similar datasets.

REPORT: Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to

Advance a Culture of Health, Babcock, S. (2017). State's \$200M MD THINK program to bring data analytics to social services. *Technical.ly Baltimore*. Retrieved from

<https://technical.ly/baltimore/2017/03/10/hogan-md-think-social-services-data/>

Rubin, V., Ngo, D., Ross, A., Butler, D., and Balaram, N. (2018). Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health. *PolicyLink*.

Retrieved from

http://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf

EXAMPLE of DATA RESOURCE:

Maryland Department of Health – Environmental Public Health Tracking Program

<https://phpa.health.maryland.gov/oehfp/eh/tracking/Pages/home.aspx>

Maryland Environmental Public Health Tracking Program is a gateway to environmental and health data resources. On this tracking site, you can create data [Tables](#) and [Maps](#) or view a [Gallery](#) of different health topics in Maryland.

COUNTY AND STATE AGENCY TEMPLATES:

Websites for data sharing agreements.

Disclaimer: Please note that these are not recommendations, simply items reviewed by the workgroup during the creation of this document.

Centers for Medicare and Medicaid Services. (2018). *Sample Interagency Data-Sharing Agreement*. Retrieved from

<https://www.cdc.gov/cancer/ncccp/doc/sampleinteragencydatasharingagreement.doc>

Maryland Governor's Workforce Development Board. (2016).

WIOA Memoranda of Understanding & Resource Sharing Agreements. Retrieved from

<http://www.dllr.maryland.gov/employment/mpi/mpi9-16.pdf>

The Council of Large Public Housing Authorities

<https://nche.ed.gov/downloads/forum/clpha-data-template.pdf>

Data Sharing: Creating Agreements In support of community-academic partnerships

By Paige Backlund Jarquín, MPH

Colorado Clinical and Translational Sciences Institute & Rocky Mountain Prevention Research Center

Retrieved from <http://www.ucdenver.edu/research/CCTSI/community-engagement/resources/Documents/DataSharingCreatingAgreements.pdf>

The Wage Record Interchange System (WRIS)

https://www.doleta.gov/performance/pfdocs/WRIS_Data_Share_Agree_Amended_Febr_17_2011.pdf

Elements of a data sharing agreement

<https://uwaterloo.ca/research/office-research-ethics/research-human-participants/pre-submission-and-training/human-research-guidelines-and-policies-alphabetical-list/data-sharing-or-transfer-agreements-what-are-they-and-when/elements-data-sharing-agreement-example>

Industry

GlaxoSmithKline, LLC

<https://study329.org/wp-content/uploads/2015/08/DATA-SHARING-AGREEMENT.pdf>

Appendix IX: 17 January 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday January 17, 2019 from 1:00 PM to 3:00 PM

Location: James Senate Office Building, Neall Conference Room, 2nd Floor: 11 Bladen St.,
Annapolis, MD 21401

Agenda

- | | |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1:00 PM | Welcome & Introductions |
| 1:15 PM | Final Discussion of SB340/HB1225 January 31, 2019 Report |
| 1:45 PM | Voting and Acceptance for Distribution of the Report to the Maryland General Assembly |
| 2:00 PM | Break |
| 2:15 PM | Next Steps
In February and March, the Workgroup will have monthly team conference calls.
The Workgroup will focus on the opportunity to pilot the Data Sharing Process, the HiAP Toolkit, and the optional procurement document among member organizations of the Workgroup.
The Workgroup will continue to design the organizational structure of the Health in All Policies Council.
The in-person meeting will be held on Thursday April 25, 2019. |
| 3:00 PM | Adjourn |

Notes: Attendees will need a photo ID to enter the building. The nearest public parking is in Gotts Garage. There will not be a call-in option for this meeting.

Appendix X: 17 January 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, January 17, 2019, 1:00PM to 3:00 PM

James Senate Office Building, Neall Conference Room, 11 Bladen Street, Annapolis, MD 21411

Meeting Commenced at 1:00 PM

Attendance: *Holly Arnold, Noel Brathwaite, Jennifer Eastman, Jon Enriquez, Lauren Gilwee, Kimberly Hiner, Glenda Lindsey, Steven Ragsdale, Dylan Roby, Tamara Toles O'Laughlin, Elaine Zammett, Wesley Queen, Kristanna Peris, Barbara Wingrove, Ruth Vriend, Dawnn McCleary*

I. Welcome Remarks from Wesley Queen

II. Review of January 2019 draft report

- a. Comments from workgroup members' supervisors were discussed
- b. A motion to accept the draft report was introduced by Mr. Jon Enriquez, seconded by Mr. Steven Ragsdale, and passed unanimously.

III. Visit from Senator Shirley Nathan-Pulliam

- a. The Senator thanked the members of the Workgroup for their commitment and effort to the Health in All Policies Workgroup.
- b. The Senator shared that her vision for Health in All Policies in Maryland is to have policies that are made to consider health, specifically in the areas of Housing (i.e., lead in housing) and Transportation (i.e., individuals receiving dialysis).

IV. Next Steps

- a. The Workgroup will be pursuing a pilot of the Data Sharing Process among the agencies that Workgroup members represent.
 - i. Dr. Noel Brathwaite volunteered his department, the Maryland Department of Health, Minority Health and Health Disparities, to be an active member of the pilot activity.
 - ii. A recommendation was made to start with two agencies and add two more agencies into the Data Sharing pilot activity after 60 days.
 - iii. The Workgroup will look into the possibility of completing the Data Sharing pilot activity within the topic of opioid use disorder, possibly joining an existing state grant program with the MD Department of Labor, Licensing, and Regulation.
- b. In February and March, the Workgroup will have monthly team conference calls. Teams will stay the same for now.

- c. The Workgroup will focus also on the opportunity to pilot the HiAP Toolkit and the optional procurement document among member organizations of the Workgroup.
 - d. The Workgroup will continue to design the organizational structure of the HiAP Council.
 - e. The next in-person Workgroup meeting will be held on Thursday April 25, 2019.
- V. Meeting Adjourned at 2:05pm.**
- VI.** After the meeting adjourned, Senator Shirley Nathan-Pulliam, introduced the members of the workgroup to the Maryland Senate Education Health and Environmental Affairs Committee, where she serves as Vice Chair.

Appendix XI: 25 April 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday, April 25, 2019 from 1:00 PM to 3:00 PM

Location: Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzger Rd, Adelphi MD, 20783

Agenda

- | | |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1:00 PM | Welcome |
| 1:15 PM | Team Breakout Sessions
<u>Team C:</u> Discuss membership of a HiAP Council.
<u>Team D:</u> Discuss dissemination and implementation ideas for data sharing process.
<u>Team F:</u> Discuss how to incorporate the optional procurement document with Healthiest Maryland Businesses.
<u>Team T:</u> Discuss dissemination ideas for HiAP Toolkit. |
| 2:15 PM | Break |
| 2:30 PM | Team Report-Outs |
| 3:00 PM | Adjourn |

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XII: 25 April 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, April 25, 2019 from 1:00 PM to 3:00 PM

Wilson H Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Meeting Commenced at 1:00 PM

Attendance: *Holly Arnold, Veronika Carella, Cheryl De Pinto, Farah Farahati, Kimberly Jones, Karen Koski-Miller, Glenda Lindsey, Steven Ragsdale, Dylan Roby, Matthew Rowe, Karen Thompkins., Elaine Zammett, Wesley Queen, Dawnn McCleary, Kristanna Peris, Lana Duerte*

I. Welcome Remarks from Wesley Queen

II. Remarks on Behalf of Senator Nathan-Pullium

- a. The Senator sends her regrets for not being able to attend the meeting but thanks every member for their service on this Workgroup.
- b. The Senator would like to see a list of all the policies related to health that each State agency has in the appendix of the final report.

III. Break Out Sessions

IV. Report Outs from Teams

- a. Team C
 - i. Team C created a list of potential agencies/members to be represented on a HiAP Council which including:
 1. Maryland Transit Authority; Department of Public Safety and Correctional Services; Department of Aging; Department of Health – Office of Minority Health; Commission on Civil Rights; Maryland Community Health Resource Commission; Department of Education; Department of Agriculture; Department of Juvenile Services; Department of Labor, Licensing, and Regulation; Department of Planning; Emergency Management Services; Maryland Health Alliance; Commission on Civil Rights; Maryland Children Environmental Commission; and the Association of County Health Officers.
 2. Academic subject matter experts from an academic institution, including: University of Maryland School of Public Health; MSUSPH; and Johns Hopkins.
 3. A member representing the Black Mental Health Alliance

- 4. A public citizen representing the public either by county or region.
 - ii. Team C will likely recommend that legislation be created proposing a Health in All Policies Council.
 - b. Team D
 - i. Team D's Data Sharing Process document in the January 2019 report should be included, as is, in the June 2019 Report to the Maryland General Assembly.
 - ii. The Team will talk with the Maryland Department of Health to discuss a data sharing pilot.
 - c. Team T
 - i. The Toolkit was not created based on a framework since the HiAP Council has not identified a single framework. Instead, the toolkit is informed by the CDC's Policy Process Framework and features best practices.
 - ii. At this point, the Toolkit may need to be renamed as a Sample Toolkit, pending the approval of the HiAP Council.
 - d. Team F
 - i. Team F will make the same recommendation as in the January 2019 Report for the June 2019 Report.
 - ii. The optional procurement document will be edited, based on feedback from representatives from Healthiest Maryland Businesses.
- V. Next Meeting: Thursday, May 23, 2019 from 1:00 to 3:00pm. Location TBD.
- VI. Meeting Adjourned at 2:56pm.

Appendix XIII: 23 May 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday, May 23, 2019 from 1:00 PM to 3:00 PM

Location: Maryland Hospital Association, 6820 Deerpath Rd, Elkridge MD, 21075

Agenda

- | | |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1:00 PM | Welcome |
| 1:15 PM | Team Breakout Sessions
<u>Team C:</u> Discuss membership of a HiAP Council.
<u>Team D:</u> Discuss dissemination and implementation ideas for data sharing process.
<u>Team F:</u> Discuss how to incorporate the optional procurement document with Healthiest Maryland Businesses.
Team T: Discuss dissemination ideas for HiAP Toolkit. |
| 2:15 PM | Break |
| 2:30 PM | Team Report-Outs |
| 3:00 PM | Adjourn |

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XIV: 23 May 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, May 23, 2019 from 1:00 PM to 3:00 PM

Maryland Hospital Association (MHA), Board Room, 6820 Deerpath Rd, Elkridge MD, 21075

Meeting Commenced at 1:13 PM

Attendance: *Farah Farahati, Lauren Gilwee, Kimberly Hiner, Laura Howard, Kimberly Jones, Karen Koski-Miller, Dylan Roby, Brian Sims, Neal Karkhanis, Wesley Queen, Dawnn McCleary, Sarah Hurlbert, Lana Duerte**

I. Welcome Remarks from Wesley Queen

II. General Discussion

- a. The sunset date for SB 340 is June 30th, 2019. Mr. Queen will recommend extending the work of the Workgroup till September 30th, to pilot test the recommendations this will strength the final report when it is presented to the General Assembly.
 - i. During the 3 month period we will establish the HiAP Council
 - ii. A letter will be sent to current members thanking them for their service to the workgroup and inviting them to join the HiAP Council for the pilot testing.
 - iii. One of the objectives during the extension will be to address one of the areas listed in the legislation (see page 2 and 3)
 - iv. Following a discussion regarding decision making authority we will continue providing copies of workgroup decisions to appropriate managers of the workgroup members if required.
- b. Representatives from MHA believe that HiAP is important to the Total Cost of Care Model in MD
- c. Funding of the future HiAP Council was discussed.
 - i. A member of the workgroup has agreed to explore funding options.
 - ii. To continue that effort we will use the Fiscal note for the 2016 HiAP Bill (SB 304 2016) to assist in the funding request

III. Toolkit Presentation and Discussion

- a. Lana Duerte* gave a presentation of the Draft toolkit to those in attendance. The group recommended the need to add an executive summary. A second Draft is being developed and will be available for the June meeting.

- b. The toolkit was created using the CDC Policy Framework.
- IV. Closing**
 - a. Team F has identified a few business that are willing to pilot test the CDC prevention checklist. Mr. Queen suggested having a monetary incentive be added to the program.
- V.** Next Meeting: Thursday, June 27, 2019 from 1:00 to 3:00pm. Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783.
- VI.** Meeting Adjourned at 2:59pm.

* Lana Beatrice Castro Duarte, MPH Health Equity graduate, created the toolkit for her Capstone Project

Appendix XV: 27 June 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday, June 27, 2019 from 1:00 PM to 3:00 PM

Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Agenda

- | | |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1:00 PM | Welcome |
| 1:15 PM | Team Breakout Sessions
<u>Team C</u> : Discuss membership of a HiAP Council.
<u>Team D</u> : Discuss dissemination and implementation ideas for data sharing process.
<u>Team F</u> : Discuss how to incorporate the optional procurement document with Healthiest Maryland Businesses.
<u>Team T</u> : Discuss dissemination ideas for HiAP Toolkit. |
| 2:15 PM | Break |
| 2:30 PM | Team Report-Outs |
| 3:00 PM | Adjourn |

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XVI: 27 June 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, June 27, 2019 from 1:00 to 3:00pm.

Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Meeting Commenced at 1:20 PM

Attendance: *Veronika Carella, Farah Farahati, Kimberly Jones, Neal Karkhanis, Andrea Lasker, Dylan Roby, Brian Sims, Karen Thompkins, Elaine Zammett, Wesley Queen, Dawnn McCleary, Sarah Hurlbert*

I. Welcome Remarks from Wesley Queen

II. General Discussion

- a. The sunset date for SB 340 is June 30th, 2019. The Extension to September 30th has been approved by the Senate president and Speaker of the House.
- b. Indication from members who are going to continue with the work group through September 30th is needed if not already received.
- c. The HiAP Council Funding Plan Draft was presented (Attached)

III. Data Sharing Open Discussion

- a. The greatest challenge is to show why data sharing is important in HiAP
- b. The main discussion focused on the Post Conference Call Notes from David Mann (Attached)
- c. Those in attendance discussed how the pilot should be kept simple so it can be completed during the 90-day Extension
- d. Creation of a standard data use agreement and a standard process to be used by agencies and organizations
- e. Including a PICO (Problem, Intervention, Comparison, Outcome) guide to help stake holders define their problem was discussed

IV. Toolkit Presentation and Discussion

- a. The current draft of the toolkit (Attached) was presented at the meeting and shared to the entire work group on June 28th. Notes and comments from members are requested by July 30th.
- b. An Asset map of programs being implemented by state agencies was requested
 - i. Please fill out the Attached Form to Aid our endeavor to create an Assets Map.
 - ii. Please email to Sarah (shurlbe@terpmail.umd.edu) by July 22nd, 2019.

- V. Closing**
 - a. Dr. Thomas would like to gauge interest in the SOPHE Advocacy Summit in October
 - b. Dr. Thomas would like work group members to volunteer at MOM, September 13-14 at the Xfinity Center at UMD College Park
- VI. Next Meeting: Thursday, July 25, 2019 from 1:00 to 3:00pm. Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783**
- VII. Meeting Adjourned at 3:06pm.**

Appendix XVII: 25 July 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday, July 25th, 2019 from 1:00 PM to 3:00 PM

Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Agenda

1:00 PM	Welcome
1:15 PM	Presentations <u>PICO</u> <u>Draft HiAP Funding Plan</u> <u>Toolkit</u>
2:15 PM	Break
2:30 PM	Discussion
3:00 PM	Adjourn

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XVIII: 25 July 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, July 25, 2019 from 1:00 to 3:00pm.

Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Meeting Commenced at 1:15 PM

Attendance: Farah Farahati, Laura Howard, Kimberly Jones, Neal Karkhanis, Glenda Lindsey, Dylan Roby, Brian Sims, Stephen Thomas, Elaine Zammett, Wesley Queen, Dawnn McCleary, Sarah Hurlbert

I. Welcome Remarks from Wesley Queen

II. Remarks from Dr. Stephen Thomas

- a. The Mid Maryland Mission of Mercy (MOM) & Health Equity Festival is September 13 & 14th at the Xfinity Center on the UMD College Park Campus
- b. Dr. Thomas encourages work group members to consider volunteering for the event. Set up starts Thursday, the event is Friday and Saturday with break down Saturday evening.
- c. There are patient referral forms available for patients to be screened Thursday night and then be first in line Friday morning. If you would like some referral sheets please contact Dr. Thomas (sbt@umd.edu) or Wes Queen.

III. PICO Presentation

- a. Dr. Farahati gave a presentation on PICO
- b. The presentation is Attached

IV. Draft Council Funding Plan Discussion

- a. The Plan was discussed and is attached
- b. The timeline needs to be adjusted due to what has not yet been completed and state office's needs
- c. The final report will contain the budget projections

V. Toolkit Presentation and Discussion

- a. Lanna gave a presentation on the toolkit and the updated graphics (attached)
- b. Please send comments on the Guide to Sarah so changes can be made for the final report
- c. It was clarified that the Toolkit conforms to the outline developed by Team T
 - i. This is a task the Council may be able to take on at a later date

VI. Closing

- a. **Teams must have sections for final report sent to Sarah on or before August 8th**
- VII.** Next Meeting: Thursday, August 29, 2019 from 1:00 to 3:00pm. Location: TBD
- VIII.** Meeting Adjourned at 3:05pm.

Appendix XIX: 29 August 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Thursday, August 29th, 2019 from 1:00 PM to 3:00 PM

Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi MD, 20783

Agenda

1:00 PM	Welcome
1:15 PM	Discussion on September 2019 Report
2:15 PM	Break
2:30 PM	General Discussion
3:00 PM	Adjourn

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XX: 29 August 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Thursday, August 29, 2019 from 1:00 to 3:00pm.

Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783

Meeting Commenced at 1:30 PM

Attendance: Noel Brathwaite, Veronika Carella, Kimberly Jones, Glenda Lindsey, Senator Shirley Nathan-Pulliam, Karen Thompkins, Kim Poole, Stephen Thomas, Elaine Zammett, Wesley Queen, Dawnn McCleary, Sarah Hurlbert

- I. **Welcome Remarks from Wesley Queen**
- II. **Items to be Added to September 2019 Report**
 - a. Recommendation 5 from the January 2018 Report
 - b. The January 2018 Executive Summary and 32 item list will be Appendix I
 - c. The January 2019 Executive Summary will be Appendix II
- III. **Data Sharing Discussion**
 - a. It was suggested that the department of the Environment and the department of Planning may be interested in participating in a Data Sharing Pilot
- IV. **HiAP Council Funding Plan Discussion**
 - a. Potential sources of funding:
 - i. Baltimore Gas & Electric
 - ii. Wells Fargo Social Responsibility fund
 - b. Funding goal: raise 50% of the budgeted amount
 - c. The budget is presented as an estimate of future income and expenditures
- V. **Closing**
 - a. The University of Maryland maintains an online archive for Minority Health and Health Equity
 - i. Found: <http://hdl.handle.net/1903/21769>
- VI. Next Meeting: **Friday**, September 27, 2019 from 1:00 to 3:00pm. Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzert Rd, Adelphi MD, 20783
- VII. Meeting Adjourned at 3:05pm.

Appendix XXI: 27 September 2019 Meeting Agenda



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

University of Maryland School of Public Health, Center for Health Equity – Workgroup on Health in All Policies Act of 2017 (SB 340/HB1225)

Date & Time: Friday, September 27th, 2019 from 1:00 PM to 3:00 PM

Location: Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzerott Rd, Adelphi MD, 20783

Agenda

- | | |
|---------|----------------------------------------------------------------------------------------------|
| 1:00 PM | Welcome |
| 1:15 PM | Final Discussion on SB 340/HB 1225 September 2019 Report |
| 2:15 PM | Break |
| 2:30 PM | Voting and Acceptance for Distribution of the Report to the Maryland General Assembly |
| 3:00 PM | Adjourn |

Notes: Parking is free and available; there will not be a call in option available for this meeting.

Appendix XXII: 27 September 2019 Meeting Minutes



3302 SPH Building #255
College Park, Maryland 20742-2611
301.405.8859 TEL 301.405.2542 FAX
www.healthequity.umd.edu

Meeting Minutes

SB340/HB1225 Health in All Policies Workgroup Meeting

Friday, September 27, 2019 from 1:00 to 3:00pm.

Wilson H. Elkins Building, Chancellor's Board Room, 3300 Metzgerott Rd, Adelphi MD, 20783

Meeting Commenced at 1:30 PM

Attendance: *Veronika Carella, Cassie Shirk, Brian Sims, Karen Thompkins, Elaine Zammett, Wesley Queen, Dawn McCleary, Sarah Hurlbert*

- I. Welcome Remarks from Wesley Queen**
- II. Final Discussion the September 30th 2019 Report**
- III. Vote on September 30th, 2019 HiAP Report**
 - a. A motion to accept and distribute the report was introduced by Veronika Carella and seconded by Brian Sims.
 - b. Those present unanimously accepted the September 30th, 2019 HiAP Report and the motion passed.
- IV. Closing**
 - a. Elaine shared the Senator's gratitude for the work the workgroup has accomplished.
- V. Meeting Adjourned at 2:11pm.**

Appendix XXIII: Extension Request Letter to President of the Senate

SHIRLEY NATHAN-PULLIAM
Legislative District 44
Baltimore City and Baltimore County

—
Vice Chair
Education, Health, and
Environmental Affairs Committee



THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
Miller Senate Office Building
11 Bladen Street, Suite 2 West
Annapolis, Maryland 21401
410-841-3612 · 301-858-3612
800-492-7122 Ext. 3612
Fax 410-841-3613 · 301-858-3613
Shirley.Nathan.Pulliam@senate.state.md.us

—
District Office
4200 Edmondson Avenue, Suite 103
Baltimore, Maryland 21229
410-947-7050 · Fax 410-947-7052

June 6, 2019

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House H-107
100 State Circle
Annapolis, Maryland 21401

Dear President Miller,

I am writing in regard to the University of Maryland School of Public Health, Center for Health Equity - Workgroup on Health in All Policies, (SB340-2017), which is due to terminate June 30, 2019. I respectfully request an extension of September 30, 2019, by which the final report can be submitted.

While we have made great strides, the Workgroup is still in the process of collecting data from various resources. Once we receive the essential information, we will be able to produce a comprehensive final report.

Thank you for taking this into consideration and I look forward to your response.

Sincerely,

A handwritten signature in cursive script that reads "Shirley Pulliam". The signature is written in dark ink on a light-colored background.

Shirley Nathan-Pulliam Senator

Appendix XXIV: Extension Request Letter to Speaker of the House

SHIRLEY NATHAN-PULLIAM
Legislative District 44
Baltimore City and Baltimore County

Vice Chair
Education, Health, and
Environmental Affairs Committee



THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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11 Bladen Street, Suite 2 West
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410-841-3612 · 301-858-3612
800-492-7122 Ext. 3612
Fax 410-841-3613 · 301-858-3613
Shirley.Nathan.Pulliam@senate.state.md.us

District Office
4200 Edmondson Avenue, Suite 103
Baltimore, Maryland 21229
410-947-7050 · Fax 410-947-7052

June 6, 2019

The Honorable Adrienne Jones, Speaker
H-101, State House
100 State Circle
Annapolis, Maryland 21401

Dear Speaker Jones,

I am writing in regard to the final report of University of Maryland School of Public Health, Center for Health Equity - Workgroup on Health in All Policies, (SB340-2017), which is due June 30, 2019. I respectfully request an extension of September 30, 2019, by which the final report can be submitted.

While we have made great strides, the Workgroup is still in the process of collecting data from various resources. Once we receive the essential information, we will be able to produce a comprehensive final report.

Thank you for taking this into consideration and I look forward to your response.

Sincerely,

A handwritten signature in cursive script that reads "Shirley Pulliam".

Shirley Nathan-Pulliam
Senator

Appendix XXV: Workgroup Members

Name	Title	Organization	Team
Senator Shirley Nathan-Pulliam	Senator	Maryland State Senate	
Delegate Robbyn Lewis	Delegate	Maryland House of Delegates	
Holly Arnold	Deputy Director, Planning and Programming	Maryland Transit Administration	F
Cheryl Austein Casnoff, MPH	Senior Fellow	NORC at the University of Chicago	
Cynthia Baur, Ph.D	Director, Horowitz Center for Health Literacy	School of Public Health, UMD	T
Sharon Baucom	Chief Medical Director	Department of Public Safety and Correctional Services	T
Noel Brathwaite, Ph.D, MSPH	Director, Minority Health and Health Disparities	Maryland Department of Health	D
Veronika Carella	MD CEHC Legislative Director	Maryland Children's Environmental Health Coalition	D
Monica Davis	Public Service Scholar	Maryland Department of Health	D
Cheryl De Pinto, MD, MPH, FAAP	Medical Director, Office Population Health Improvement	Maryland Department of Health	T
Jan Desper Peters	Executive Director	Black Mental Health Alliance	C
Emily Dow, Ph.D	Assistant Secretary, Academic Affairs	Maryland Higher Education Commission	F
Jennifer Eastman	Director, Community Living Policies	Maryland Department of Disabilities	F
Jon Enriquez, Ph.D.	Director, Research, and Policy Analysis	Maryland Higher Education Commission	T
Farah Farahati, Ph.D	Lecturer/Senior Health Economist	Department of Economics, UMBC	F

Rachael Faulkner	Director of Research and Policy Development	Public Policy Partners	F
Lauren Gilwee	New Americans Initiative Coordinator	Maryland Department of Labor, Licensing, and Regulation, Division of Workforce Development and Adult Learning	T
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Laura Howard	Senior Program Manager, Community Benefit	Kaiser Permanente	C
Kimberly Jones	Director, Office of Government Affairs and Communications	Maryland Department of Health	F
Karen Koski-Miller	Director of Social Work	Department of Public Safety and Correctional Services	T
Andrea Lasker	Special Assistant for Policy and Program Development	Department of Public Works & Transportation Prince George's County Government	T
Glenda Lindsey, Dr. P.H., M.S., R.D.N., L.D.	Nutritionist, Public Health Consultant	Maryland Academy of Nutrition and Dietetics	T
Mark Luckner	Executive Director	Maryland Community of Health Resources Commission	F
Ruth Maiorana	Executive Director	Maryland Association of County Health Officers	T
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Deborah Nelson	Section Chief, Specialist	Maryland State Department of Education, School Safety and Climate, School Psychological Services	C

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Keshia Pollack Porter, Ph.D., M.P.H.	Professor, Director, Institute for Health and Social Policy, Department of Health Policy and Management	Johns Hopkins Bloomberg School of Public Health	T
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Steven Ragsdale, MSL	Healthcare Management & Cultural Competency Consultant	Consultant	C
Dylan Roby, Ph.D	Associate Professor, Department of Health Services Administration	School of Public Health, UMD	F
Matthew Rowe	Assistant Director, Water and Science Administration	Maryland Department of the Environment	D
Kathy Ruben	Executive Director	Consumer Health First	D
Darlene Saunders	Special Projects Manager, Health & Wellness Division	Prince George's County Health Department	T
Nicholette Smith-Bligen	Acting FIA Executive Director	Maryland Department of Human Resources	D
Cassie Shirk	Director, Legislation and Government Affairs	Maryland Department of Agriculture	C
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Caroline Varney-Alvarado	Special Assistant	Department of Housing and Community Development	C
Cheri Wilson	Consultant	Consultant	F
Jennifer Witten	Director of Government Relations	Maryland Hospital Association	D
Elaine Zammett	Chief Staff	Office Senator Shirley Nathan-Pulliam	C
Brian Sims	Director of Quality & Health Improvement	Maryland Hospital Association	
Neal Karkhanis	Director of Government Affairs	Maryland Hospital Association	
Jonathan Coplin	Executive Assistant to Deputy Secretary	Maryland Department of Transportation	
Nathan McCurdy		Maryland Department of Legislative Services	
Dawnn McCleary		Legacy Leader	
Barbara Wingrove		Legacy Leader	
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