JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 309
Favorable

TO: The Honorable Shane Pendergrass, Chair
House Health and Government Operations Committee

FROM: Dr. Sherita Hill Golden, M.D., M.H.S.
Hugh P. McCormick Family Professor of Endocrinology and Metabolism
Vice President, Chief Diversity Officer, Johns Hopkins Medicine

DATE: January 26, 2021

Johns Hopkins University and Medicine supports **House Bill 309 – Public Health – Data – Race and Ethnicity Information.** This bill requires the Maryland Health Care Commission ("MHCC") and the Health Occupations Boards ("Boards") to publish annually the Health Care Disparities Policy Report Card ("Report"). That Report would include the racial and ethnic composition of the individuals who hold a license or certificate issued by a health occupations board established under the Health Occupations Article. This would also mandate response to requests for health data that includes race and ethnicity information within 30 days after receipt of the request. This bill further mandates that the Department of Health meet with the MHCC annually to: 1) examine the data that includes race and ethnicity in the state, and 2) identify any changes to improve the health data that is accessible in the Office. Lastly, the bill requires the health occupations board issuing a license or certificate to include a form for the license or certificate or renewal application that would provide the applicant's race and ethnicity information, and, the bill also requires the board to encourage an applicant to provide race and ethnicity information on the application.

Diversity and inclusion is a core value of Johns Hopkins Medicine. As an institution it remains dedicated and committed to reducing health disparities that are present throughout the State of Maryland. Health disparities, unfortunately, have been a long-standing systemic problem in the Black, Hispanic, and Indigenous communities. The COVID-19 pandemic has only further exacerbated these disparities and has heightened the need for this and other legislation aimed at reducing this blight in our communities. Nationally, Black and Indigenous Americans continue to suffer the highest mortality, with both groups experiencing a COVID-19 death toll exceeding 1 in 750. Latino, Black, and Indigenous Americans all have COVID-19 death rates of double or more that of White and Asian Americans (https://www.apmresearchlab.org/covid/deaths-by-race). In Maryland, African Americans/Blacks are 29% of the population but account for 33% of COVID-19 cases and 36% of COVID-19 deaths; Latinx account for 10% of our state's population but 19% of COVID-19 cases (https://covidtracking.com/race/dashboard#state-md).

An important contributor to health and health care disparities is the lack of a diverse biomedical workforce that reflects the racial and ethnic diversity of the communities served by medical establishments. Following the publication of the famous Flexner Report in 1910, which changed medical school training from proprietary to being based on the biomedical model, many medical schools in the United States were closed. These closures

disproportionately impacted medical schools training Black physicians—of the 7 medical schools open at that time, only Howard Medical School and Meharry Medical College remained following implementation of the Flexner Report. This has had sustained and long-term impacts on the diversity of the biomedical workforce. A recent study in the *Journal of the American Medical Association Open Network* showed that if those closed medical schools training Black physicians had remained open, they would have trained an additional 35,000 Black physicians by 2019 (Campbell et al, *JAMA Network Open*, 2020). According to the American Association of Medical Colleges, only 5% of practicing physicians in the United States are Black/African American. Similarly, just under 6% are Hispanic/Latinx and <1% are Indigenous (https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018). In order to deliver high quality culturally appropriate care, it is critical to increase diversity of not only the physician work force but also, all of the health care workforce. In order to establish benchmarks and metrics for our State, it is important to collect data on our current biomedical workforce.

At Johns Hopkins Medicine, we recognized the critical need for collecting accurate demographic data on our healthcare workforce. We are building a dashboard to track key metrics of our health care workforce by race/ethnicity, sex, and their intersection, including job category and rank for faculty and staff; salary by rank for faculty and staff; years at rank in a given role for faculty and staff; terminations/departures, and reductions in force. We believe that diversity and inclusion in health care is a matter of life and death as biases may impact clinical decision making that directly impacts our patients. During COVID-19, we were able to engage our diverse workforce to support the needs of our Spanish-speaking patients. For example, we launched the *Juntos* program that sought to reduce cultural and language isolation for Latinx patients and their families by connecting them with bilingual clinicians.

Accurately collecting and analyzing self-identified demographic data to support workforce diversity, along collecting accurate patient demographic data, and mandating unconscious and implicit bias training, are critical steps in reducing health disparities. The time to act is now. Similar to two other bills before this Committee, House Bill 309 is yet another opportunity to create an equitable, inclusive environment for health care delivery to which all of our patients are entitled. Johns Hopkins University and Medicine urges a **favorable report on House Bill 309 – Public Health – Data – Race and Ethnicity Information.**

cc: Members of the House Health and Government Operations Committee
Delegate Joseline Pena-Melnyk