MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, August 01, 2024 | 2:00 – 5:00 PM EDT
Prince George's County Government Building (Hybrid)
1801 McCormick Dr, Upper Marlboro, MD 20774, USA

MEETING MINUTES

Commissioners present (in person or virtually)
Christopher Brandt
Meena Brewster
Camille Blake Fall
Nilesh Kalyanaraman
Oluwatosin Olateju
Frances Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg

Commissioners absent
Del. Heather Bagnall
Jean Drummond
Alyssa Lord
Boris Lushniak

Commission vacancies
Urban Local Health Officer
Senate Representative

I. Call to Order

Co-Chair Meena Brewster called the August 2024 meeting of the Maryland Commission on Public Health to order at 2:06pm. Dr. Brewster made opening remarks and thanked everyone for attending. She also acknowledged Prince George's County and Dr. Matthew Levy for their hospitality in hosting the Commission meeting. Co-chair Brewster asked Dr. Egboluche to call the roll. A quorum was established to conduct business.

II. Adoption of the Agenda

Dr. Brewster introduced the agenda for review and approval. A motion was made and seconded to adopt the agenda. The agenda was adopted without comment.

III. July 11, 2024 Minutes Review and Approval

Co-chair Brewster noted the July 11, 2024 meeting minutes were distributed electronically ahead of today's meeting and copies were available in the back of the room for review. She asked for comment. Commissioner Nicole Rochester noted her name was incor rectly spelled in several places with an *H* and asked for the scrivener's error to be corrected. Commissioner Fran Phillips moved to approve the minutes with amendment, Co -chair Olateju seconded. The minutes were approved without dissent; Dr. Brewster abs tained since she was not present at the July meeting.

IV. **Guest Presentation** by Dr. Georges C. Benjamin, Executive Director of the American Public Health Association

Co-chair Brewster asked Co -Chair Olateju to introduce the guest speaker for the meeting, Dr. Georges C. Benjamin, Executive Director of the American Public Health Association. Dr. Benjamin acknowledged his multiple perspectives over the course of career, having served in clinical settings, local public health settings, in executive leadership at the Maryland Department of Health, and now as an advocate of public health in the nonprofit sector. He offered remarks on the state of public health today and opp ortunities to improve the system.

Dr. Benjamin noted that the public health system evolved over time and was not strategically created at a particular point in time. Rather, it is a partnership between state, federal, local, and nonprofit entities. Whil e many partners operate in this space and would say they are doing the work of public health, Dr. Benjamin contends that governmental public health is the only entity on the hook and cannot walk away. Nonprofits and associations can help extend the suppor t of public health, serving as capacity extenders and early warning systems.

Despite the myriad of concerns about how to quantify or measure the work, Dr. Benjamin noted that public health is highly scrutinized and has many mechanisms that ensure performa nce and accountability, such as auditors, accreditation boards, and policymakers who exercise oversight functions. Even so, funding and support seem to follow the crisis curve with temporary increases in funding and lasting increases in performance expect ations. This is especially challenging as crises exist in context of other challenges – mental health needs, chronic disease burden, and other barriers that do not disappear despite the changing priority. For example, basic public health issues persisted during the COVID-19 pandemic response.

Lessons learned and research from earlier outbreaks such as HIV/AIDS and SARS helped lead to more effective COVID -19 response, especially therapeutics such as monoclonal antibodies and mRNA vaccines. The public health system has the capacity and charge to continue this type of system innovation and amplification of past lessons learned.

Dr. Benjamin highlighted how technology and social media have changed the practice of public health. Innovations in informa tion dissemination and communication have democratized the field and scientific messaging is now competing with social media that now drives individual health behaviors and decisions. This leads to health policy being overtly political.

Next generation p ublic health system has to be robust and sustainable. The ideal

role for the health officer at any level is to be Chief Health Strategist with an agency structured to deliver the 10 essential services. This means going forward that:

- Data and IT system must be actionable and modern to match current needs
- Harmonize statutory authorities across jurisdictions
- Adequate/sustainable funding
- Vibrant, cross-sector partners
- Accountable accredited systems

Dr. Benjamin remarked that he felt the structure of Maryland's public health system is a national model of what a health and human services mega agency ought to look like as it contains all the essential functional areas to ensure delivery of essential public health services. Even so, there are opportunities for improvement, but overall it is a great setup. Particular features he felt important to ensure were retained or further improved are:

- Every jurisdiction has a local health officer as Chief Health Strategist by law
- Agency structured to deliver 10 essential/foundational services
- Maryland Department of Health data systems are ripe for innovation and interoperability
- Funding could be improved and made more sustainable. The All-payer system in Maryland is a game changer and could lead the way to provide more flexibility in the system.
- Businesses/private sector are under-utilized and under-engaged in partnerships
- Many local health departments and the state health department are accredited by the Public Health Accreditation Board (PHAB)

Specific changes that Dr. Benjamin identified were strengthening core public health infrastructure, incentivizing workforce pipelines into governmental public health, creating state of the art health info & data exchange pathways, linking systems across sectors, and requiring accreditation and accountability across all health entities. Dr. Benjamin then answered questions from the Commission and workgroup members.

V. Break

Co-chair Brewster moved the recess up on the agenda in light of the time and noted that Commission updates would occur after the brief recess. The meeting recessed at approximately 3:45pm.

VI. Commission Updates

The Commission resumed business at approximately 4:00pm. Co-chair Brewster

asked Mr. Hatchett to provide updates on the Commission's activities. Mr. Hatchett briefly discussed the Commission's overall project timeline, key activities for the remainder of the calendar year, and the upcoming deep dive report outs from the workgroups. He noted in particular that attendance at the deep dive sessions would be instrumental for Commissioners and the value of the dialogue was critical to identifying initial themes for recommendations.

VII. Public Health System Assessment Overview

Dr. Brewster asked Dr. Kleinman to introduce the assessment partners and offer remarks.

Brittany Bugbee discussed how the assessment partners intended to collect and analyze the data for the assessment responses. She noted that more than 200 questions were generated by workgroups. Academic partners categorized them into six themes: organizational structure; funding; communicating health information; technology and data systems; workforce; partner and public engagement. Workforce was a cross-cutting theme in some ways; several workgroups had questions about training and education needs. Challenges, needs, and health equity were identified as cross-cutting themes. Review of the FPH services showed that most services were covered in questions submitted, but not all areas. The assessment will include nearly 100 stakeholder interviews and key informant interviews. Ms. Bugbee gave an overview of potential protocols and ways the partners are working to make sure the data collection is representative and respectful of participants' time. Interviews will be offered by zoom and phone.

Dr. Anita Hawkins talked about the ways in which public perspectives will be included in the assessment. This includes the public listening sessions, online comments, and potentially a public survey.

The Commissioners discussed the proposed protocols and general themes of submitted questions. It was noted that health equity has been identified as a core item of interest and cross-cutting theme, but the questions shown in the presentation did not reflect that. Ms. Bugbee acknowledged it was not representative of the full slate of questions, but that there were multiple questions within each area that touched on equity themes. She indicated they were willing to continue refining those and engaging subject matter experts to ensure the questions reflected the priorities of the Commission.

VIII. Announcements

Co-Chair Brewster then made announcements. She highlighted the upcoming Talbot County Health Department Site Visit and Eastern Shore Listening Session and asked Commissioners and workgroup members to do their best to attend. She noted the next monthly meeting of the Commission will be Thursday, September 5

in the same location at Prince George's County Govern ment Building from 2:00 pm to 5:00 pm. Dr. Boris Lushniak will preside.

IX. Adjournment

Seeing that the business had been concluded, Dr. Brewster invited a motion to adjourn. Commissioner Nicole Rochester moved to adjourn the meeting; Commissioner Michelle Spencer seconded. The motion was approved without dissent and the Commission adjourned its monthly meeting at 4:55pm.