MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, October 3, 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)
Boris Lushniak
Oluwatosin Olateju
Meena Brewster
Camille Blake Fall
Nilesh Kalyanaraman
Frances Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Del. Heather Bagnall
Allen Twigg
Sen. Clarence Lam
Jean Drummond

Commissioners absent
Alyssa Lord
Christopher Brandt

Commission vacancies
Urban Local Health Officer

I. Call to Order
Co-Chair Oluwatosin Olateju called the October 2024 meeting of the Maryland Commission on Public Health to order at 2:04pm. Dr. Olateju made opening remarks and thanked everyone for attending. She also acknowledged Prince George's County for their hospitality in hosting the Commission meeting. Co-chair Olateju asked Dr. Egboluche to call the roll. A quorum was established to conduct business.

II. Adoption of the Agenda
Dr. Olateju introduced the agenda for review and approval. A motion was made and seconded to adopt the agenda. The agenda was adopted without comment.

III. Motion to approve September Minutes
Olateju moved to adopt September minutes; a motion was made by Camille Blake Fall and seconded by Boris Lushniak. Nicole Rochester abstained since she was not present at the September meeting.

IV. Workforce Panel
Guest panelists included Dr. Crystal Devance-Wilson (Director of MD Nursing Workforce Center), Dr. Ann Kellogg (Director of Reporting Services, MD Longitudinal Data System Center and MD Higher Education Commission), and Dr. Carolyn Nganga-Good (Deputy Director of Health Resources Services Administration (HRSA), at the U.S. Department of Health and Human Services. All three panelists discussed the value in researching the workforce, especially addressing any barriers to PH and nursing practice in advancing the health of the population of MD, looking at primary care vs population health.

Introductions
Co-Chair Olateju asked for Co-Chair Boris Lushniak to introduce one of the guest

speakers for the meeting, Dr. Devance-Wilson. Devance-Wilson is a board certified public health clinical nurse specialist with 30 years of experience working in acute and community settings with diverse populations. She is also an Assistant Professor at the University of Maryland School of Nursing where she has been employed for the past 15 years teaching in the graduate and undergraduate programs.

Co-Chair Dr. Meena Brewster introduced Dr. Ann Kellogg, the second of the three panelists. Dr. Kellogg works as the Director of Reporting Services at MD Longitudinal Data System Center and Maryland Higher Education Commission. Kellogg's work examines the educational and workforce outcomes of Marylanders by using longitudinal data that links education to workforce records to provide analyses to stakeholders to make informed policy decisions.

The third panelist, Dr. Carolyn Nganga-Good was introduced by the presiding Chair of the meeting Dr. Oluwatosin Olateju. Dr. Nganga-Good is an advanced public health nurse administrator with extensive nursing and public health management experience. Dr. Nganga-Good serves as the Deputy Director of the Health Resources Services Administration (NRSA) in the U.S. Department of Health and Human Services.

Dr. Kellogg was asked to expound upon her role within the MD Longitudinal Data Systems Center (MLDS). She explained MLDS is an independent state agency within government that develops and maintains a data system containing student and workforce data for all levels of public education, child and youth services, and the State's workforce. They are organized into data and systems management, reporting services (where Kellogg works), and the research branch. The MLDS is governed by a 15-member governing body and the state repository for education and workforce data, including things like Foster care or vulnerable population and nursing licensure. As such, MLDS generates timely and accurate reports about student performance that can be used to improve the state's education system and guide decision makers at all levels.

Dr. Nganga-Good has been a champion of the nursing workforce since the beginning of her career, combining what she has taken away from her experiences in government and local health departments. Dr. Nganga-Good noticed gaps in care, specifically during COVID, and emphasized it's important to have a diverse, prepared workforce. She made special mention of the fact that overseeing a grant which investigated population health, the issues that we have are not unique to Maryland, that there are gaps across states.

Dr. Kellogg discussed the nursing support program and the subsequent analysis, and that the program was working favorably to accelerate bachelor's degree programs. Kellogg also made special mention of the fact that LDSC supported the Healthcare Workforce Crisis Commission (HWCC), specifically the workforce data advisory group. This group looked at the healthcare workforce broadly (focusing on rationale and trend data (including graduation rates and wages 3, 5, and 10 yrs out). The analysis revealed that suspicions were not true (that people were not opting out of the healthcare workforce), however the healthcare workforce started to decline in the 5-10 year mark and move out of hospitals (specifically 5 and 10 year marks) and into offices. Other factors such as people wanting to start a family or wages took them out of the hospital setting; Dr. Kellogg underscored the importance of data supporting these findings.

Dr. Olateju prompted Dr. Devance-Wilson to explore what is keeping nurses in the profession. A study done with a variety of nurses (LPNs, CNAs and advanced practice

nurses) done in 2021; survey showed two distinct barriers:
1) 83% asked for better financial incentives, wanted hazard pay (as a result) and increases in retirement contribution, better benefits
2) 74% wanted better nurse to patient ratios, and staffing conditions (decreasing numbers in LDH nurses); available resources were not sufficient with driving demand for public health services.

Dr. Nganga-Good survey regarding PH Nursing Workforce Study interviewed nurse leaders from 19 LHDs and 2 school districts. The interview findings revealed:
1) that PH nurses (LDH and school health) are an aging and diminishing workforce. Nearly half of the health dept respondents revealed that they do not have a chief nursing officer or a director of nursing (leadership) positions.
2) the average age was 54 (80% were over the age of 46); highly experienced workforce (over 25 yrs experience), but a lot of positions were not being filled/replaced.

Some of the top barriers to PHN practice were things like: financial, salary, workload/staffing, access to resources, lack of advancement opportunities, leadership, access to health care for clients, poor communication. Subsequently, ideas that would promote practice of public health nursing are: improved salary and employee benefits, ensuring PH funding and resources, increased PH and PHN awareness, improved education and training opportunities, improved access and services, streamline and standardize policies, showcase PH and PHN recognition, and improved leadership, advocating for PH and PHN.

Some common concerns from regional meetings are in the area of leadership (no PHN leader position at MDH, lack of leadership skills and succession planning, no local professional nursing organization, poor recognition, respect and value, poor funding for PH) and workforce issues (low salary, hiring and retention barriers, aging, lack of incentives, advancement, incentives for advanced education, and unmet education and training needs).

Dr. Olateju invited Dr. Kellogg to speak about how MLDS is addressing workforce shortages. As mentioned before, the Healthcare Workforce Crisis Commission looked at the healthcare pipelines, but different roles in healthcare sectors. She also mentioned the Behavioral Healthcare Investment Fund and provided data to them
and they looked broadly at BH, public administration, public health; graduate production, what majors people are deciding on and the report will come out soon.

Dr. Nganga-Good discussed the role that the federal government and other agencies play in data sharing and capacity building to improve academic practice. She highlighted that the main finder for academic research and development comes from the federal government. Fed gov’t supports surveys that inform local health departments too. Capacity building comes from participating in federal advisory councils, so that PH Practitioners can inform where the needs are. Funding piece is the most important and determines where it’s allocated.

Dr. Devance-Wilson discussed dedicated workforce grants (one is an NSB2 grant and another that it is a dedicated education grant). The latter is an academic practice partnership where the program hires a clinical instructor who is part of the practice organization working there as a nurse. hire the academic partner and hire them as a clinical instructor, which helps facilitate orientation, nurse if very familiar with the

environment. They pair the preceptor with the students (1:1) and have an immersive experience, embedded into the organization. Students have a kind of internship with organizations they are working at; one at Adventist Healthcare in Montgomery County and one in Prince George's County.

The MD Workforce Center aligns its goals with the AHEAD model to transform primary care. The Workforce center can help with discerning the numbers of caregiving models, for ex: it is estimated by 2036 there will be 14,000 NP in state vs 7,000 jobs, thus knowing the needs for primary care and mental health is critical. It also helps support BH goals too, getting them in school and helping them socialize. In addition, there are different kinds of training and education and providing more opportunities will enhance the programs. Salaries and benefits must stay competitive and provide incentives for growth. Another hurdle is that the recruitment process takes a long time. Streamlining the recruitment process and retaining them is key, in addition to recognition opportunities we can offer.

Maryland Projects is informing BH workforce and outcomes in state by providing collaboration [i.e. tailored workshops offered for each group, as well as training for trauma groups (maternal/infant deaths)], and wellness recommendations [questions about job satisfaction, work injury, bullying in the workplace; AACN talking about it and doing their own wellness, issues of retention, workforce significantly impacted by COVID-19]. Kellogg pointed out that there are ample collaboration opportunities and they are happy to partner with anyone with the CoPH and issues tied to workforce retraining. Devance-Wilson said it's crucial to start thinking about different models, providing nurse residency programs and internships/externships.

V. Commission Updates

a. Final Interim Report framework and timeline
    i. Outlining final report
        1. Draft report up by about a month
        2. Talking about it in June 2025
        3. Facilitate more engagement
        4. No draft ready by December 1, but by December 14

VI. Break

VII. Workgroup Deep Dive - Communications and Public Engagement: Dr. Tonii Gedin and Dr. Sylvette La Touche-Howard; followed by commission discussion and reflection

a. Public Assessment
b. Perceptions, thoughts and attitudes
c. Lots of engagement
d. Every month - 3rd Thursday
e. Surveys: MACHO PH Info officers (PIOs) Group
    i. What do they do?
    ii. What would they like to see more?
f. Conferences: ASPPH
g. Topics included Commission on PH Charge, MD Foundations for Community Engagement & Communications, Composition, Role and Challenges of Comms within LHD, as well as State HD, Coph Workgroup Charters and timeline
h. Experts consulted; 4 interns reviewed 50 articles, 200 hrs spent

i. Health Equity and Cross-Cutting Themes
    i. Using culturally appropriate language and community engagement
        1. Written translation
        2. On-site interpreters
        3. Use of translate tech
        4. Geography (rural vs urban)
        5. Tone - implied / perceived arrogance
        6. Building relationships
        7. Differences in verbiage and vernacular based on region or culture
        8. Diversifying workforce
        9. Bidirectional information exchange with the public; encourage feedback, questions, and interactions
    ii. Incorporate health literacy training and principles into PH interventions
        1. Effective comms skills
        2. Plain language
        3. Advance language access
        4. HB 1082
    iii. Building public trust
        1. Feeling gov't ph actions are not back or based in science
        2. Addressing misinformation directly
        3. Systemic racism and historic bias in health care and gov't
        4. Not trusting of CDC or fed recommendations
        5. Timely information
        6. Community engagement - **trusted messengers**
            a. Respecting and incorporating cultural differences in delivery
        7. Consistency provide consistent messages across platforms
        8. Unbiased info
        9. Provider reassurance, support resources, and recognize the challenges people have understanding
    iv. Other Themes
        1. creating social connection
            a. Isolation of older adults
            b. emotional support programs
            c. Engaging
    v. Emerging Themes
        1. We don't know what the public wants and we just don't know enough about how people want to engage with info
        2. HD are under-resourced for robust comms and marketing
        3. Difficult for HD's to keep up with emerging tech
        4. Source of info about health is vast and we don't always have control over them
        5. we don't know what we don't know

vi. Remaining questions
    1. Survey sample demographics - who will/will not be represented?
        a. What will our subsequent steps be to target those groups?
    2. We have always wanted to know what channels are being used by the public and which channels do they trust?
        a. Our hope is that the survey will reveal some of this info
    3. For the state: where is communication on their priority list?
        a. Effective social media and marketing requires funding
    4. Who the influencers are

vii. Focus next 3-6 months
    1. What do you foresee your activities/schedule being?
        a. Promoting survey as much as possible through out channels
        b. connecting with other WG's
        c. attending commission meetings
        d. working with commission to engage media for survey publicity
        e. awaiting results

viii. Comments/questions
    1. Meena - looking at ground campaign communications
        a. Tonii - AAHD fund other orgs that are trusted within the community going out and sharing info; how are we engaging with communities
        b. Boris - acknowledges the importance of Comms WG; unless reaching the public and looking forward with approaches, it's a non-starter. Also should be tackling AI/machine thinking and incorporate the most 21st century approach
            i. Sylvette - acknowledged import of AI; we should consider what is the role of LDH and MDH?

VIII. Announcements

a. Next meeting: November 07, 2024, 2:00 – 5:00 PM at Prince George's County Government Building with virtual option

b. Upcoming North Central Regional Listening Session in Baltimore City on October 28, 2024.

c. Other deadlines/announcements
    a. November 20 meeting on calendar; will be a review of interim report

X. Adjournment

Seeing that the business had been concluded, Dr. Olateju invited a motion to adjourn. Commissioner Boris Lushniak moved to adjourn the meeting; Commissioner Meena Brewster seconded. The motion was approved without dissent and the Commission adjourned its monthly meeting at 4:53pm.