MARYLAND COMMISSION ON PUBLIC HEALTH

September 05, 2024
2:00 PM – 5:00 PM EDT

Prince George's County Government Building (Hybrid)

In-person: 1801 McCormick Dr (Rm 140), Upper Marlboro, MD 20774

Online: **https://meet.google.com/whc-wzpa-osc**
or dial: (US) + 1 314 474-3289 Pin: 228 226804#

More phone numbers: **https://tel.meet/whc-wzpa-osc?pin=9675008149300**

AGENDA

I. Call to Order

II. Adoption of the Agenda

III. August 01 Minutes Review and Approval

VI. Guest Presentation: Chad Perman, MDH Office of Primary Care

VII. Commission Updates

  a. Update on LHD Site Visits and Regional Public Listening Sessions

  b. Final Interim Report framework and timeline

VIII. Short Recess

IX. Workgroup Deep Dive - Governance and Organizational Capabilities: Frances Phillips and Dr. Barbara Bookmyer

X. Commission Discussion and Reflection

XI. Announcements

  a. Next meeting: October 03, 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

XII. Adjournment

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 incorrectly 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 abstained 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 opportunities 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. While 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 support 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 performance 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 expectations. 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 information 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 public 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 Government 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.

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Welcome

September 05, 2024

This meeting will be recorded and posted on the Commission's public website.

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Roll Call

Commissioners: please say present when your name is called.

Workgroup members: please post your name and workgroup in the chat box or on the sign-in sheet.

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Adoption of Agenda

Commissioners: Please signify your voice vote by saying "aye" or "nay" when the vote is called.

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Approval of Aug. 05 Minutes

Commissioners: Please signify your voice vote by saying "aye" or "nay" when the vote is called.

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Maryland Primary Care Program (MDPCP)

Presentation to the Maryland Commission on Public Health

Chad Perman
Executive Director, MDPCP Management Office

September 5, 2024

Agenda

- Overview of MDPCP
- Key Areas of Public Health Overlap
- Accomplishments
- What's Next

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Overview of MDPCP

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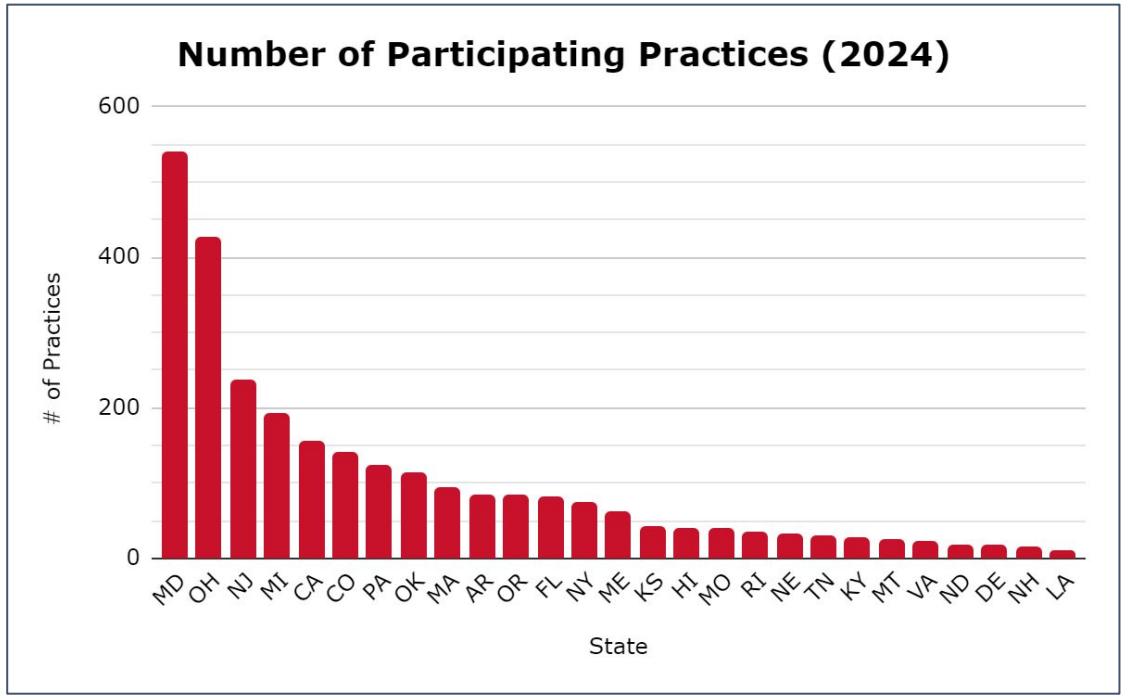
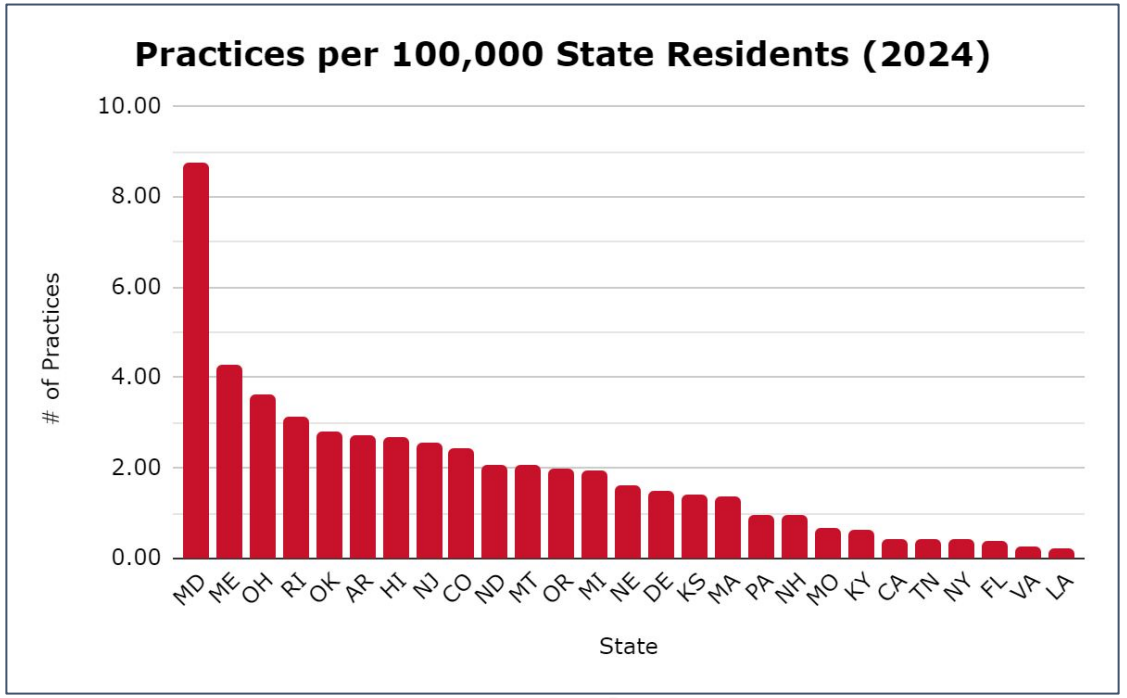
Key Facts

- MDPCP is the largest Medicare advanced primary care program in the nation. MDPCP is in the 6th year of operation and covers every Maryland county and serves approximately 4 million Marylanders.
- Approximately $200M annually in Federal dollars is sent directly to primary care practices for patient care.
- Foundation to any new Health Care Model agreement with federal government

Largest Medicare Advanced Primary Care Program in the Nation

When compared to the national Primary Care First model, MDPCP is the nation's largest advanced primary care program by state based on number of practices and practices per 100k residents.





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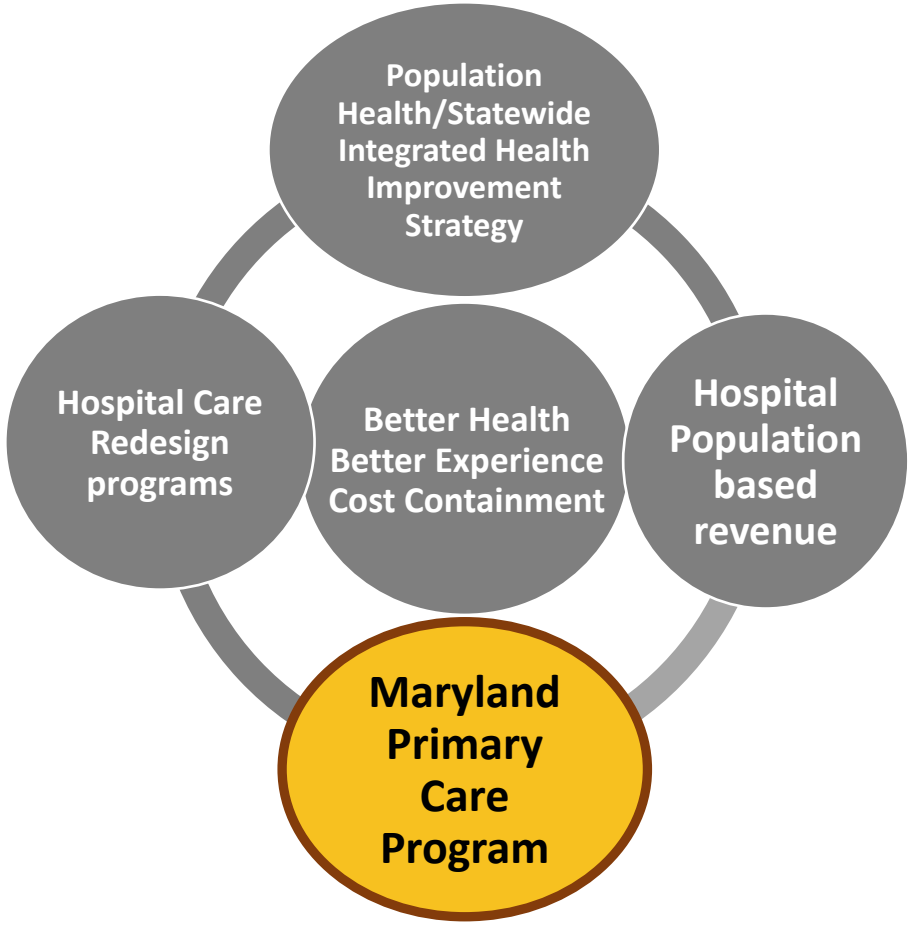
Maryland Primary Care Program (MDPCP) Supports Statewide Health Transformation

MDPCP is….

- A **statewide advanced primary care program**
- **Goal**: Build a strong, effective primary care delivery system, inclusive of medical, behavioral and social needs
- **Part of Maryland Total Cost of Care model**, a statewide healthcare delivery transformation
- **Reducing avoidable hospital utilization** by improving health and providing the best care at the right time at the right place

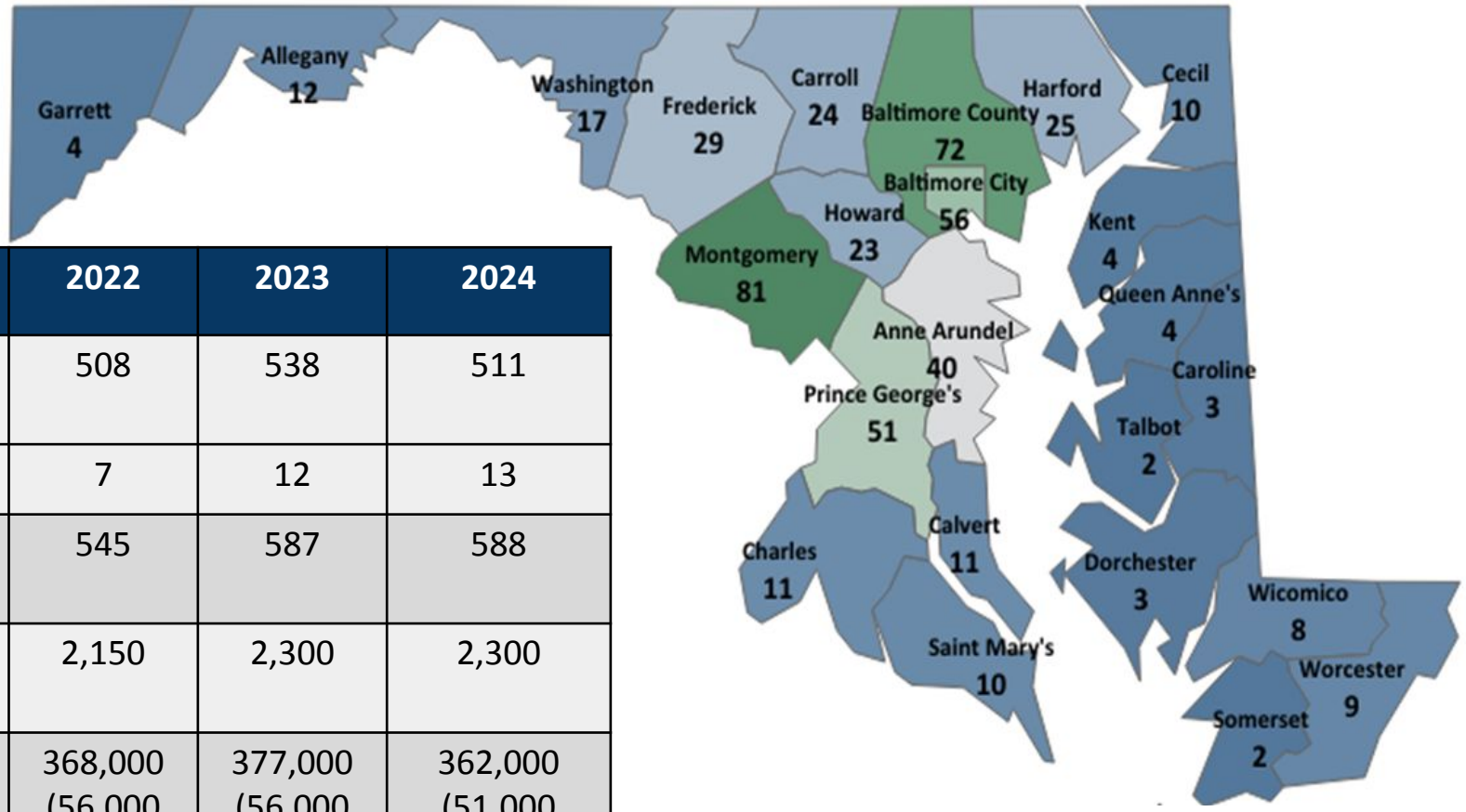
Maryland Total Cost of Care Model



MDPCP in 2024 - 511 Participating Practices

Support infrastructure – 26 Care Transformation Organizations

Statewide – Practices in every county



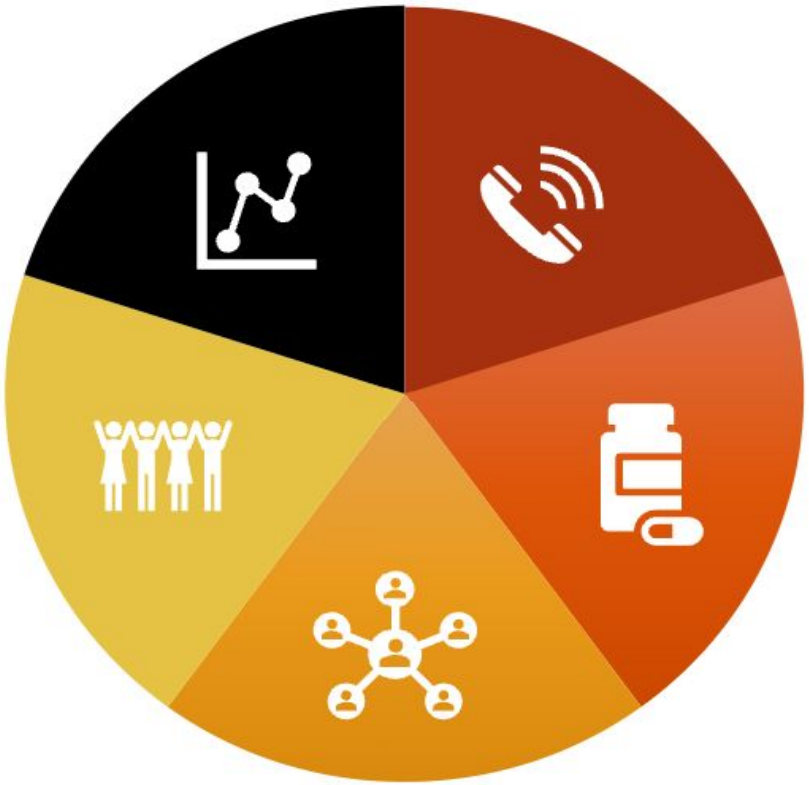
PARTICIPANTS	2019	2020	2021	2022	2023	2024
Practices	380	476	525	508	538	511
FQHCs	-	-	7	7	12	13
Total sites	380	476	562	545	587	588
Providers*	1,500	2,000	2,150	2,150	2,300	2,300
Medicare Beneficiaries attributed*	215,000 (30,000 duals)	326,000 (48,000 duals)	387,000 (58,000 duals)	368,000 (56,000 duals)	377,000 (56,000 duals)	362,000 (51,000 duals)

Largest state program in the nation through 2023 - by number of practices and practices per capita (compared to CMS' national Primary Care First Model)

*Yearly totals for these metrics are approximate and based on Q1 attribution for the corresponding year.

Implementing MDPCP's Advanced Primary Care Requirements

Care Transformation Requirements



Access & Continuity – Expanded Access | Alternative Visits (+Telemedicine)

Care Management - Risk-Stratification | Transitional Care Management | Longitudinal, Relationship-Based | Comprehensive Medication Management

Comprehensiveness & Coordination - Behavioral Health Integration | Social Needs Screening & Referral

Beneficiary & Caregiver Experience - Patient Family Advisory Councils | Advance Care Planning

Planned Care for Health Outcomes - Continuous Quality Improvement | Advanced Health Information Technology | CRISP

Overview of Tracks

Payments

TRACK 2

Advanced

Track 1 requirements + addition of offering of alternative care (e.g., telehealth) social needs screening and linkages, comprehensive medication management, and advance care planning

- Care Management Fee (CMF)
- Performance-Based Incentive Payment (PBIP)
- CPCP + standard FFS billing
- Health Equity Advancement Resource and Transformation (HEART) (if applicable)

TRACK 3*

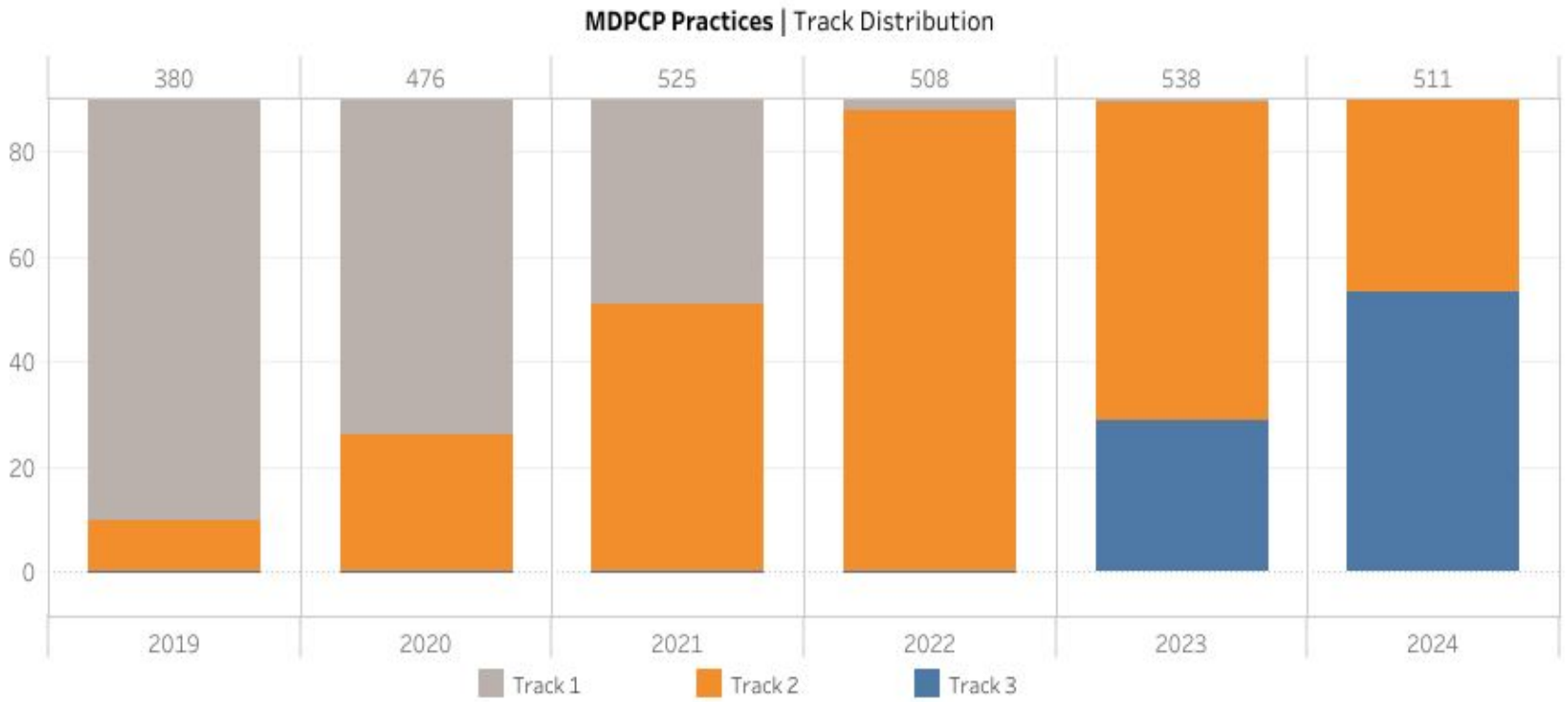
Advanced with Upside & Downside Risk

Track 2 requirements + collection of demographics data, prioritizing health related social needs, & expanded alternative care requirements

- Population Based Payment (subject to PBA)
- Flat visit fee (subject to PBA)
- Performance-Based Adjustment (PBA)
- HEART (if applicable)

*New starters must transition to Track 3 before the start of 2026.

Practices by Track



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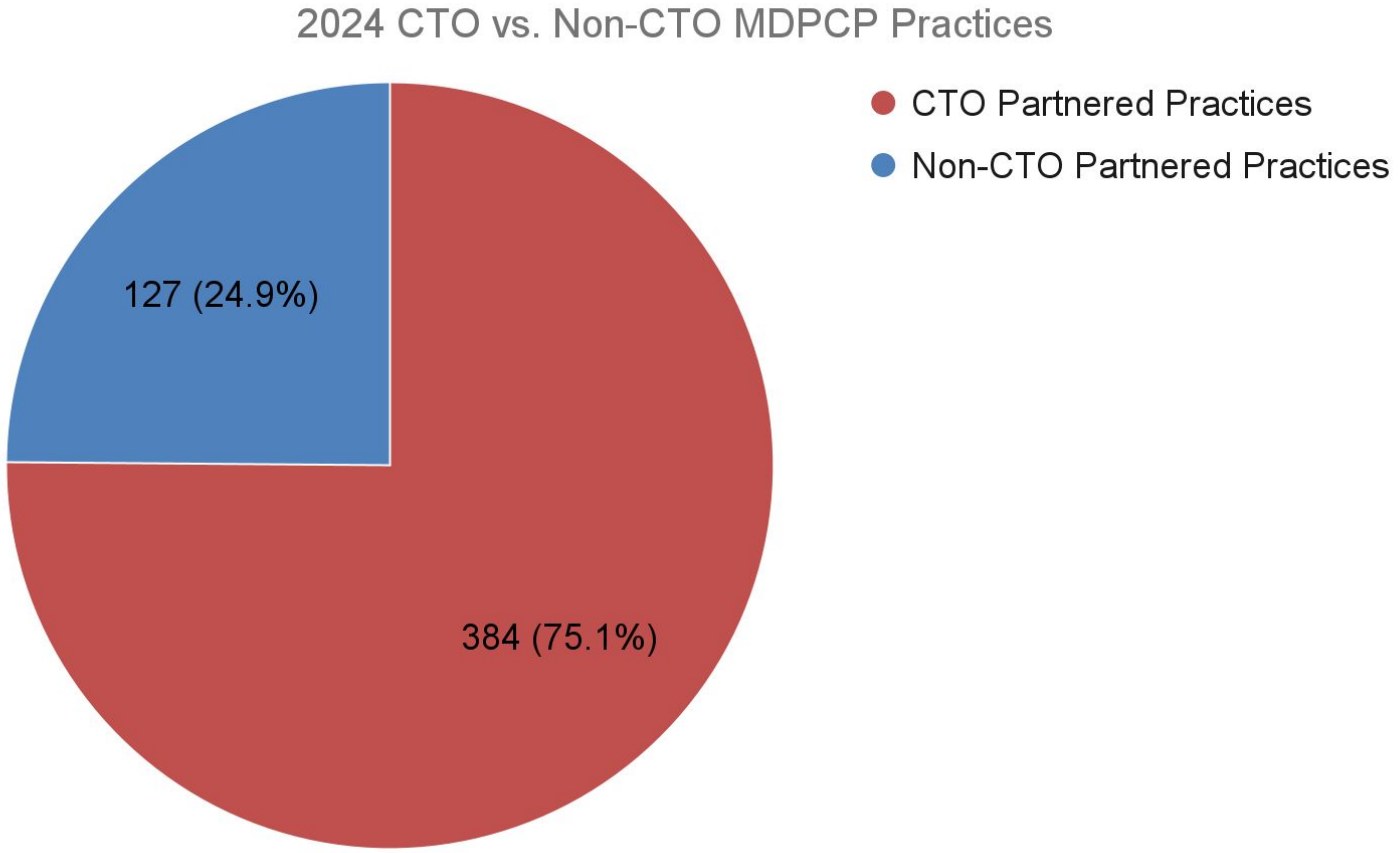
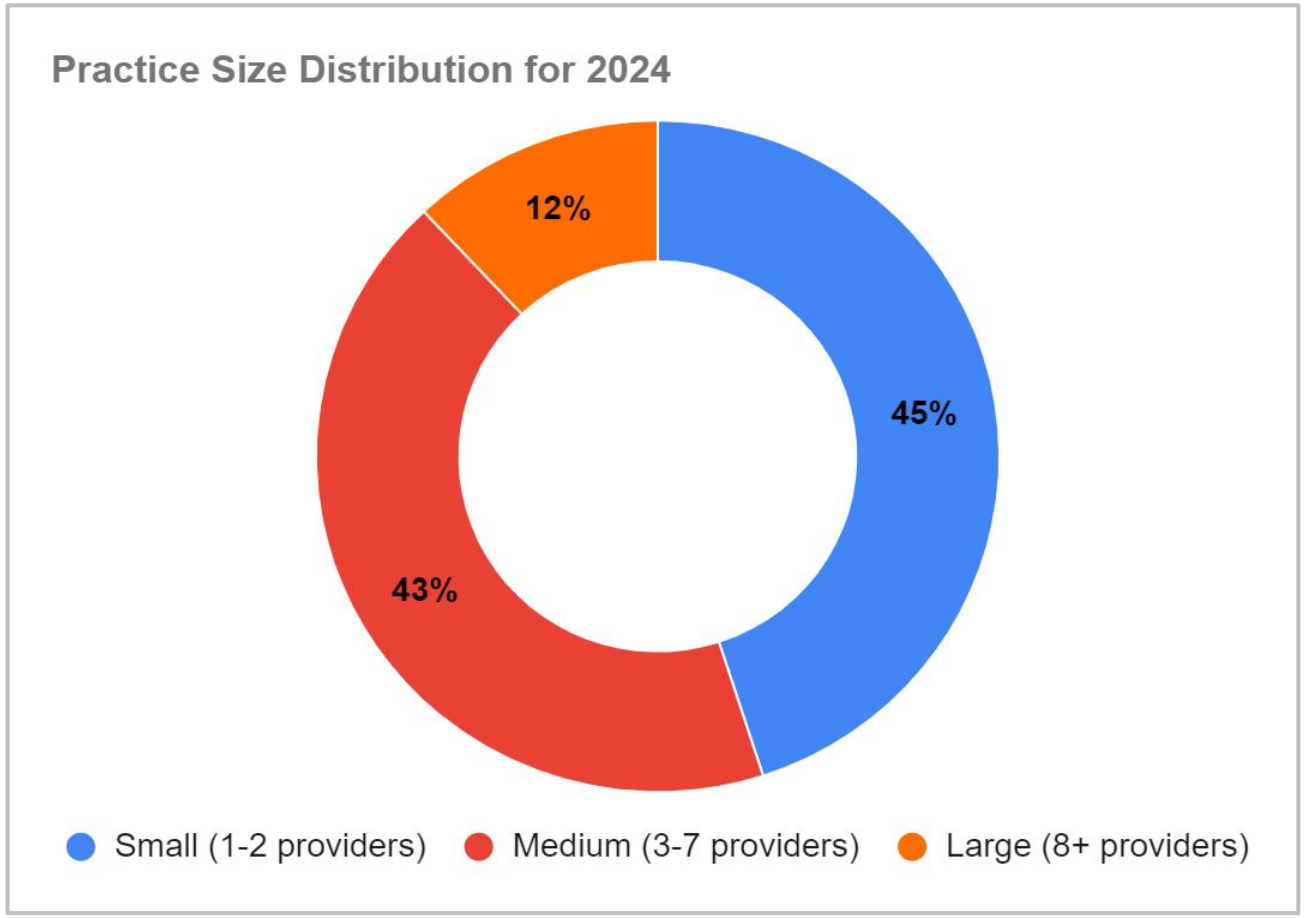
CTO Partnerships

CTOs are practice support organizations that assist practices with meeting the advanced primary care requirements including care management, data insights and behavioral and social needs



- ~75% of practices have partnered with CTOs in recent years
- ~250k Medicare beneficiaries are attributed to CTOs (69% of MDPCP beneficiaries)

2024 Practice Size



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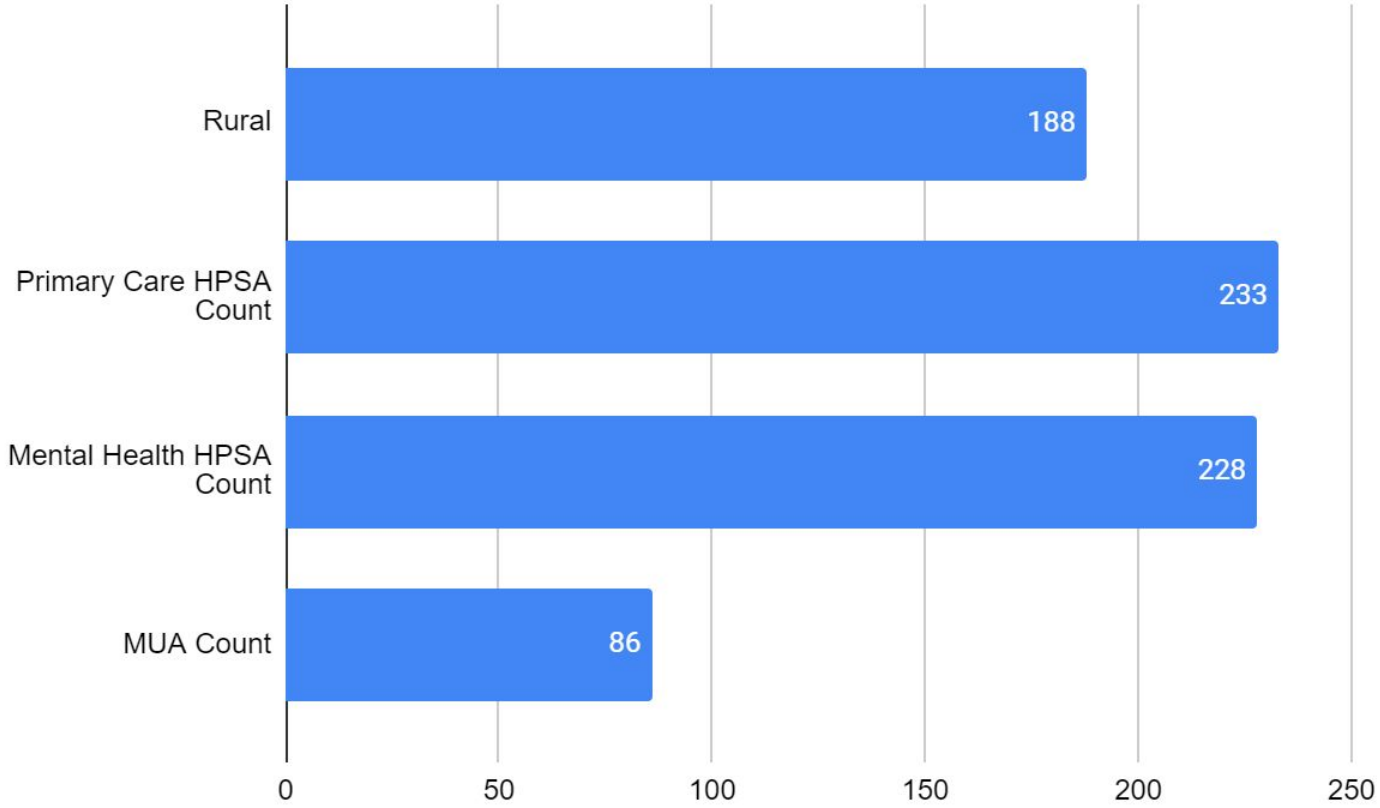
2024 MDPCP Practice Distribution by Underserved Category



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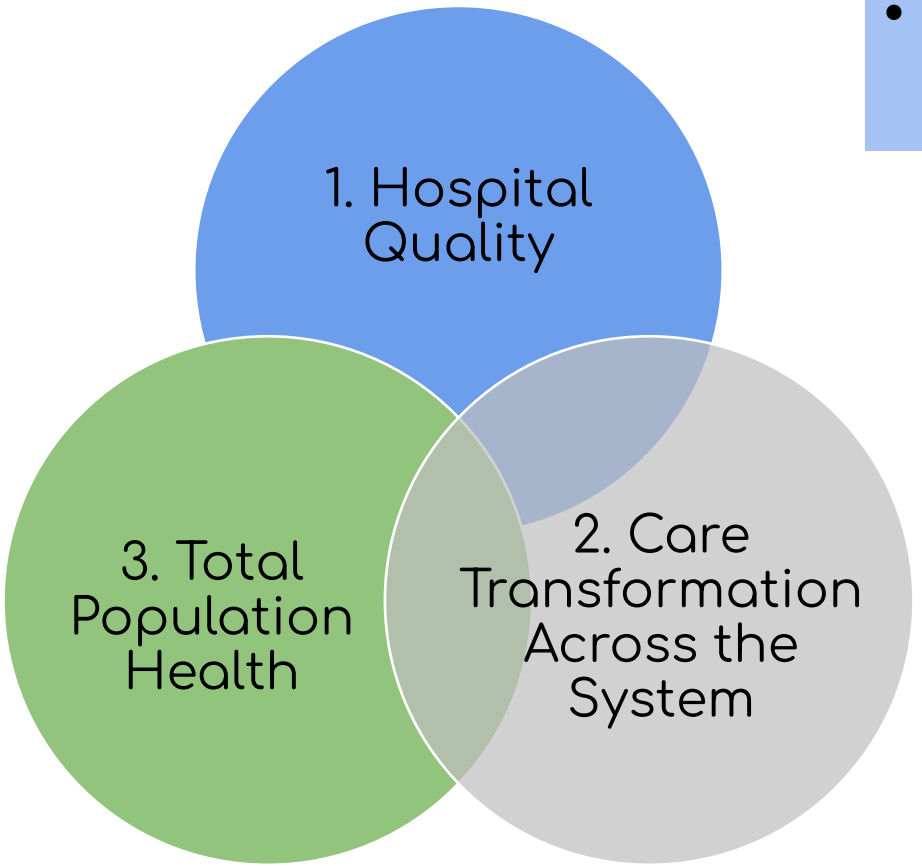
MDPCP Aligned with State's Population Health Strategy (SIHIS)



Hospital Quality

- **<u>Reduce avoidable admissions</u>**
  - MDPCP focuses on reducing PQIs by building care management infrastructure and providing CRISP/Hilltop data reports

Care Transformation Goals

- **<u>Improve care coordination for patients with chronic conditions</u>**
  - MDPCP requires 1)timely follow up for Inpatient admissions and ED visits; 2) longitudinal care management

Total Population Health Goals

- <u>Priority Area 1 (Diabetes)</u>: **Reduce mean BMI**
  - MDPCP practice performance on Diabetes A1C quality measures has improved since 2019
  - BMI and follow up plan quality measure
  - Building tools to alert practices on prediabetes and education/QI to refer to DPP
- <u>Priority Area 2 (Opioids)</u>: **Improve overdose mortality**
  - 2019 - present - implemented SBIRT into over 339 practices
  - 2024 - begun MOUD implementation
  - 2024 - non-fatal overdose alert for practices

MDPCP Payer Alignment

Alignment in 5 areas:

1. Financial Incentives/ Non-visit based payments
2. Care Management
3. Quality Measures
4. Data Sharing
5. Practice Learning

2019 — **Medicare** (Center for Medicare & Medicaid INNOVATION)

2020 — CareFirst

2025* — **Medicaid**
(*IN DEVELOPMENT)

MDPCP - Solicitation for Payer Partners (PDF)

MDH Program Management Office

Program Administration, Technical Assistance and Infrastructure

- Health Equity
- Public Health Integration
- Analysis
- Behavioral Health Integration

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MDPCP Impacts on Utilization and Costs

- **Reduced acute utilization** per 1,000 beneficiaries, 2019-2023:*
  - Reduced Avoidable hospital utilization (PQIs) by 25%.
  - Reduced Emergency Department (ED) utilization by 17%.
  - Reduced Inpatient Hospitalization (IP) utilization by 13%.
  - On all measures, MDPCP per K rates are lower than the equivalent non participating population.
- **Lower growth in Costs** Per Beneficiary Per Month, 2019-2023:*
  - Lower average annual cost growth rate compared to equivalent non-participating population. (2.77% vs. 3.48%)

*Rates are risk-adjusted, which accounts for differences in patient population illness acuity, to allow for direct comparison

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Key Areas of Public Health Overlap

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Key Tools for Public Health Infrastructure - Respiratory Disease Response for PCPs

Guides, resources, and templates

Biweekly emails with updates and information

Direct technical assistance from staff

Lab expansion project with BioMerieux

Strategies Built with the Triple Play Strategy framework

Triple Play Strategy: Vaccines, Testing, and Therapeutics

Primary Care Public Health Update:

8/30 Updates

Good afternoon Maryland Primary Care Providers and partners,

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Program Impacts: COVID-19 Spotlight

- **Higher COVID-19 vaccination rates** in all study months (Dec 2020 - March 2022)
- **12.4%** higher rate of COVID-19 vaccine boosters
- **7.6%** lower rate of overall COVID-19 cases
- **12%** lower inpatient admission rate attributed to COVID-19
- **27%** lower death rate attributed to COVID-19

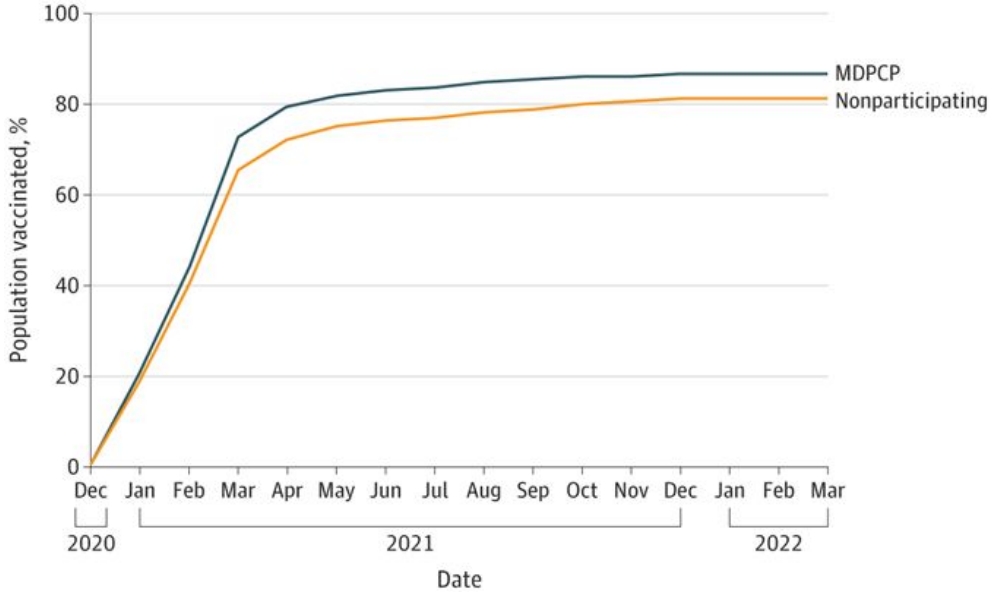


Figure. Vaccination Rates Over Time for Maryland Primary Care Program (MDPCP) and Nonparticipating Practice Groups

Reference: JAMA article, "Association of Participation in the Maryland Primary Care Program With COVID-19 Outcomes Among Medicare Beneficiaries"

Health Equity Supports

MDPCP is committed to achieving **equitable quality of care, access to care, and outcomes at the primary care level**. Four core priority areas around health equity are: data, social needs screening and referral, payment, and QI to reduce disparities.

Data

Enable all MDPCP practices and CTOs to have the foundational data capacity to understand disparities in clinical quality, utilization, and cost

Social Needs Screening and Referral

Ensure all MDPCP practices and CTOs effectively screen patients for social needs and refer patients to community resources to address those needs

Payment

Give practices the financial resources to address social needs, specifically the HEART Payment, which directs funding to target beneficiaries' social needs

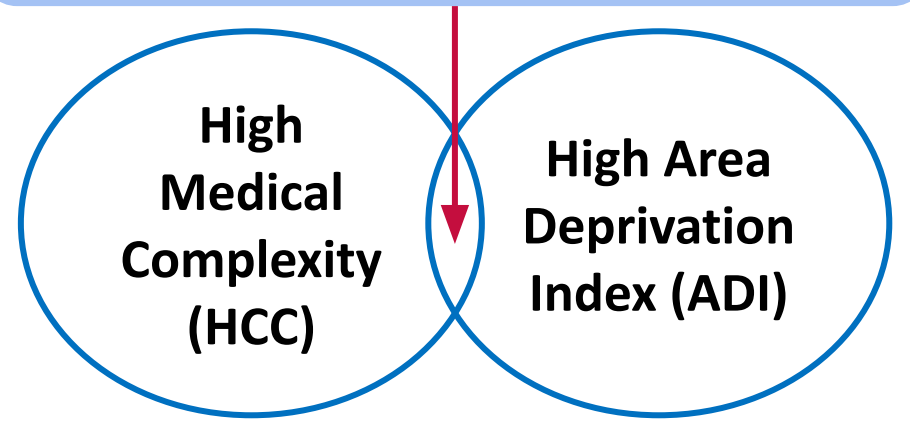
Quality Improvement to Reduce Disparities

Build QI capabilities and infrastructure within practices to reduce disparities in measures such as PQI-like events, ED events, and hospital follow up rates

HEART Payment Enables Practices to Directly Address Unmet Social Needs

What is the HEART payment?

Additional $110 PMPM for attributed MDPCP beneficiaries who have:



HEART has allowed practices to accomplish:

- Partnership with a local farm co-op to deliver packages with fresh produce for beneficiaries with food insecurity
- Purchasing stair rails for a patient who had a fall and could no longer walk up their stairs, leading to increased mobility and independence in their home
- No-cost visits with dieticians, nutritionists, and diabetes educators for support with diet and chronic disease management

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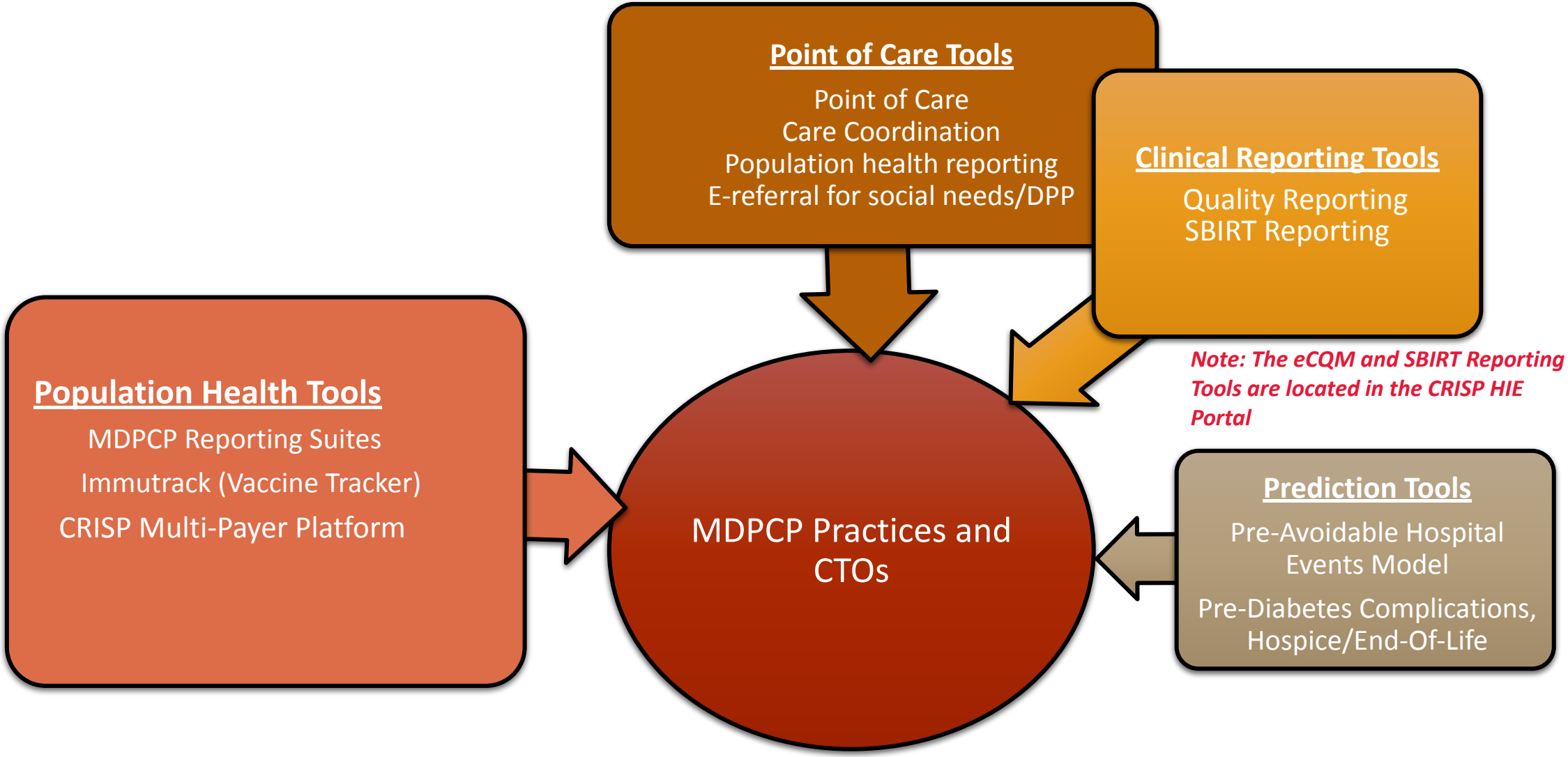
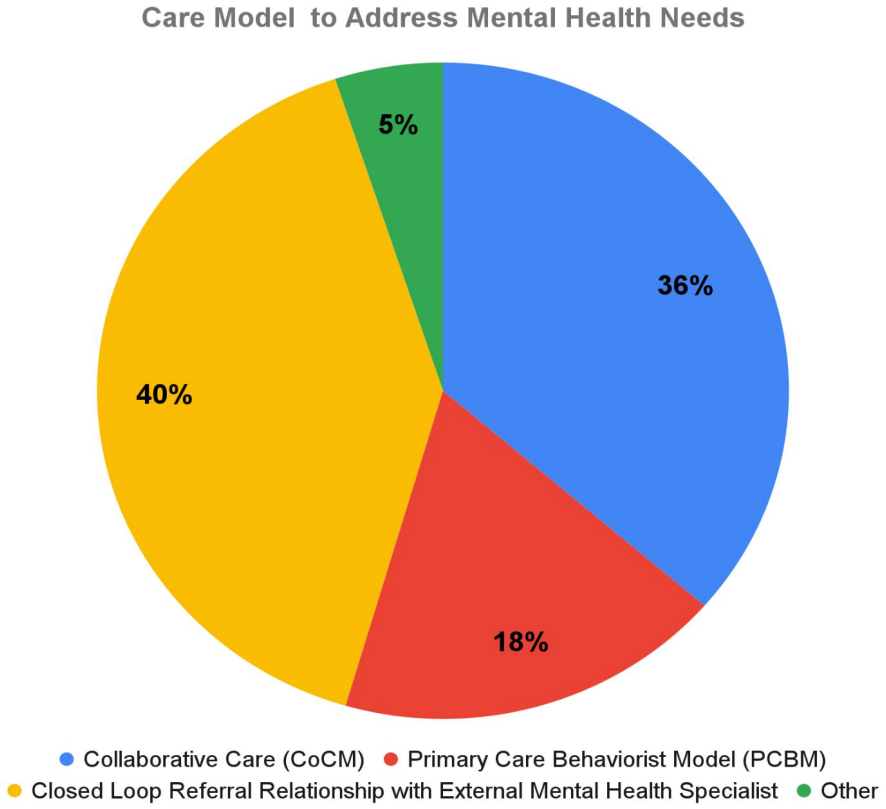
Population Health Data for Primary Care

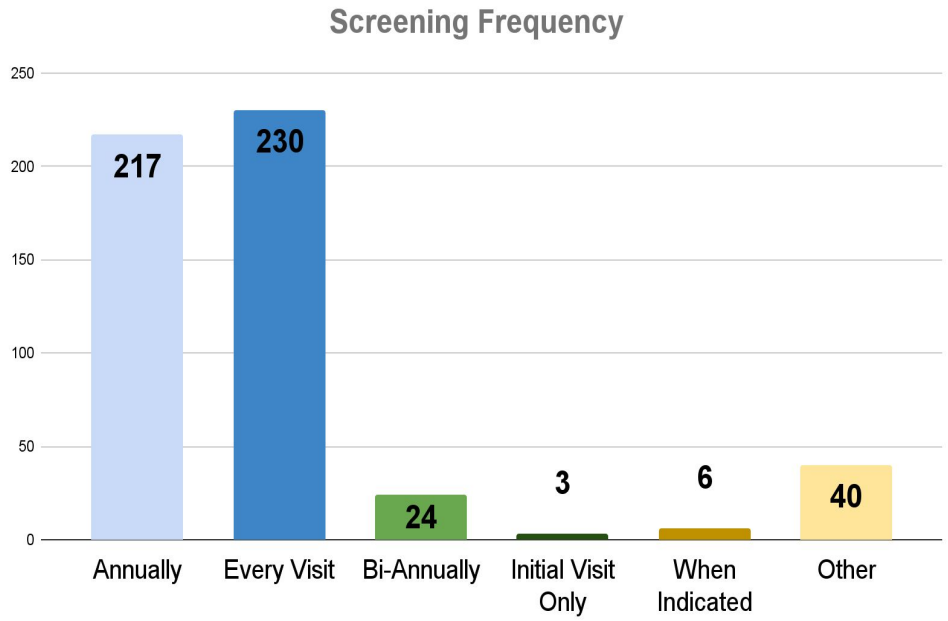


Behavioral Health Integration in MDPCP

Various models for integrating mental health services into primary care - 2023



100% of practices report routinely screening patients for mental health needs in 2023



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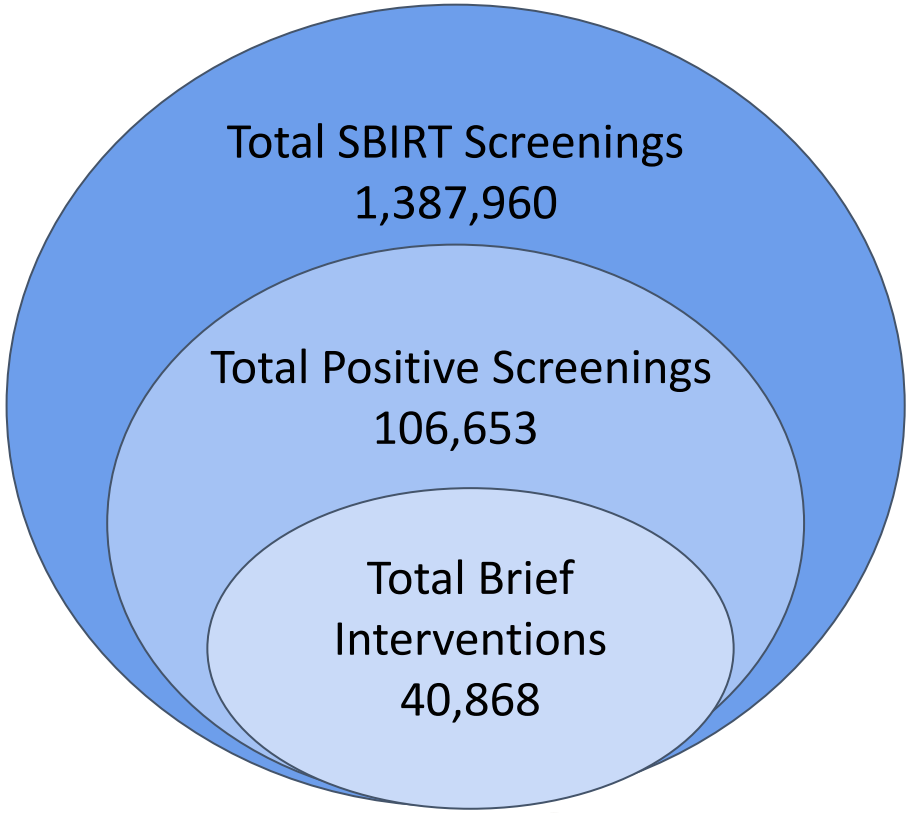
Behavioral Health Integration in MDPCP

Overall: 64% of practices have implemented SBIRT through State technical assistance

Substance Use Disorder Three-Fold Strategy

- SBIRT implementation in hotspot OUD areas.
- SBIRT data in CRISP
- MOUD implementation in hotpot OUD areas.



Data reported
Aug '21 - June '24

SBIRT: Screening, Brief Intervention, Referral to Treatment
OUD: Opioid Use Disorder
MOUD: Medication for Opioid Use Disorder
BH: Behavioral Health

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What’s Next

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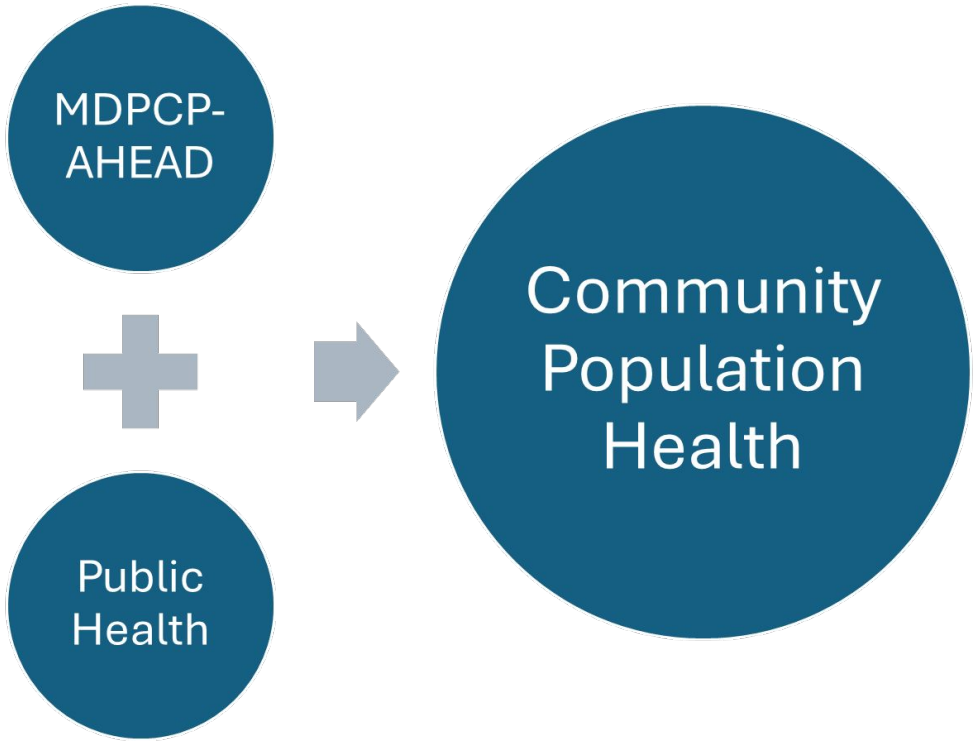
Future State - Advancing Primary Care and Public Health Integration

- **MDPCP transitions to AHEAD Model** - broadened advanced primary care approach to Medicare and Medicaid
- **Public Health entities actively partner with primary care practices** around state to address physical, behavioral and social needs



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Thank You!

Check out the MDPCP website for updates and more information

Email mdh.pcmodel@maryland.gov with any questions or concerns

Any questions?

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Commission Updates

Shane Hatchett

Timeline

	2024				2025	
	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Meeting Date, Chair	*05 Sep, Boris*	*03 Oct, Tosin*	*07 Nov, Meena*	*05 Dec, Tosin*	*23 Jan, Boris*	*20 Feb, Meena*
Focus	Deep dive into Gov. / Org Capabilities	Deep dive into Comms/PE	Deep dive into Funding; adopt interim report	Submission of interim report; review progress	Deep dive into Data & IT	Deep dive into Workforce
Assessment	• Assessment activities underway, outreach begins	• Assessment activities underway/released; guides developed	• Assessment shift to KII/focus groups • Review preliminary trends	• KII/focus groups continue • Review and analysis	• Surveys and assessments completed • Analysis underway *(except PH WINS)*	• All findings and analysis complete (except PH WINS)
System Engagement	• Chad Perman, MDH	• TBD: workforce panel • **28/Oct**: Baltimore City Site Visit • Focus groups/KII meetings begin	• TBD: DBM Secretary/Designee • Summarize site visit findings • Focus groups/KII meetings continue	• Focus groups/KII meetings continue with system partners • Submit final interim report (1 Dec)	• TBD	• TBD
Public Engagement	• *Public comment form and phone line still open*	• **28/Oct**: Baltimore City Listening Session • Public comment form and phone line close	• Summarize public comments	• Issue press release and social media campaign highlighting CoPH work	• TBD	• TBD

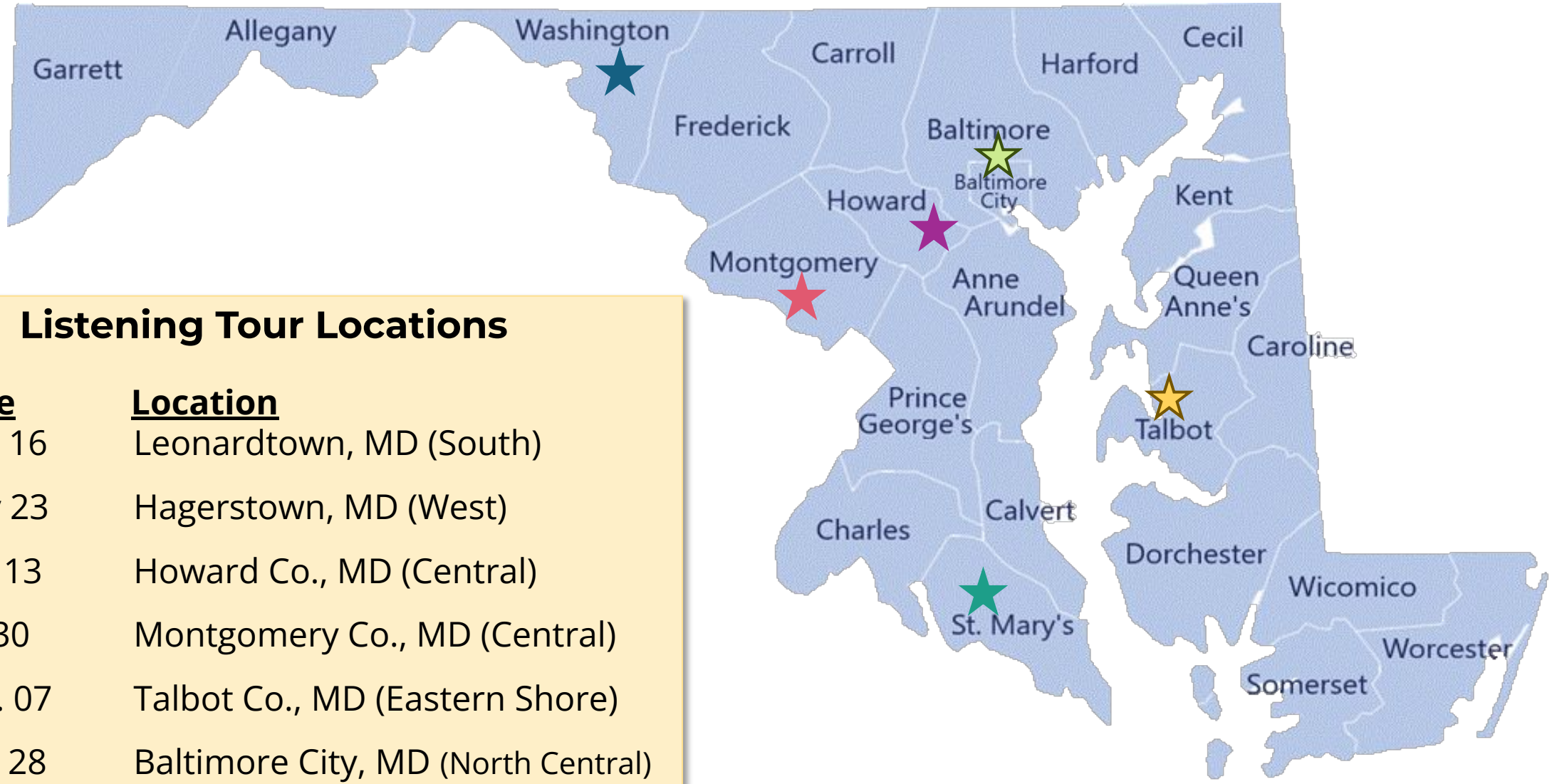
Assessment Update

- Regularly meeting with Assessment Team (biweekly) to coordinate
- Continuing to refine questions and respond to feedback from Commissioners and workgroups
- Managing scope vs. timeline
  - Fidelity to the statute and goals
  - Focus areas of Commission
  - Feasibility

Final Interim Report

- Template and instructions under development
- Reminder of timeline:
  - Oct. 21 - Workgroup report drafts due to Coordinators/Staff
  - Nov. 7 - Discuss and adopt report; staff will make modifications based on feedback
  - Dec. 1 - Submit Final Interim Report on or before this date

Listening sessions



Listening Tour Locations

Date	Location
Apr. 16	Leonardtown, MD (South)
May 23	Hagerstown, MD (West)
Jun. 13	Howard Co., MD (Central)
Jul. 30	Montgomery Co., MD (Central)
Aug. 07	Talbot Co., MD (Eastern Shore)
Oct. 28	Baltimore City, MD (North Central)

Current as of 30 August 2024. Check website for updates.

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Break

September 05, 2024

The Commission has temporarily recessed and will reconvene soon. Recording will continue.

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Deep Dive: Governance & Organizational Capabilities

Fran Phillips, RN and
Barbara Brookmyer, MD
Co-Chairs

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Adjourned

September 05, 2024

The next Commission meeting is October 03.

Chad Perman

Executive Director, Maryland Primary Care Program Management Office, Maryland Department of Health

Mr. Perman has served as the Executive Director of the Maryland Primary Care Program Management Office since September 2021. He previously served as the Program Director.

On behalf of the Maryland Department of Health, Mr. Perman was a member of a small team that co-designed the innovative advanced primary care program with the Centers for Medicare and Medicaid Services from 2016 to 2017. He now oversees Maryland's $200 million annual partnership with CMS, Medicare's largest state based advanced primary care program in the Nation. Focused on integrating public health and primary care, Mr. Perman has been a key advisor to the Maryland Department of Health on health transformation and population health initiatives since 2015.

Mr. Perman previously served as the Director of Health Systems Transformation within the Department's Office of Population Health Improvement. Prior to working for the State, Mr. Perman served as a consultant with Health Management Associates (HMA). Mr. Perman conducted health policy analyses and provided consulting services to public- and private-sector clients focused on publicly financed health care.

Mr. Perman has also presented at a variety of state and national meetings as well as authored several peer-reviewed publications. His abstract, "Innovative Payment Mechanisms in Maryland Hospitals' ' was selected as the 2014 Best of Academy Health Research Meeting. Mr. Perman leverages expertise in the areas of public policy analysis, consumer engagement, econometrics and performance measurement through a variety of engagements with federal agencies, universities and policy institutes.

Mr. Perman has also served on a variety of boards and workgroups including the Herschel S. Horowitz Center for Health Literacy (University of Maryland) Advisory Board and the Maryland Primary Care Investment Workgroup.