MARYLAND COMMISSION ON PUBLIC HEALTH

**October 03, 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. September 05 Minutes Review and Approval

VI. Guest Presentation: Workforce Panel with Dr. Crystal DeVance-Wilson (MNWC), Dr. Ann Kellogg (MD LDSC), and Dr. Carolyn Nganga-Good (MD RWJF Fellowship)

VII. Commission Updates

   a. Final Interim Report framework and timeline

   b. Staffing Updates

VIII. Short Recess

IX. Workgroup Deep Dive – Communications and Public Engagement: Dr. Tonii Gedin and Dr. Sylvette La Touch-Howard

X. Commission Discussion and Reflection

XI. 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

XII. Adjournment

MARYLAND COMMISSION ON PUBLIC HEALTH

September 5, 2024 | 2:00 – 5:00 PM EDT
Prince George's County Department of Health (Hybrid) | 1801 McCormick Dr, Upper Marlboro, MD 20774

**Meeting Minutes**

Attendees:

1. Meena Brewster
2. Jean Drummond
3. Oluwatosin Olateju
4. Boris Lushniak
5. Frances Phillips
6. Heather Bagnall
7. Michelle Spencer
8. Maura Rossman
9. Allen Twigg
10. Nilesh Kalyanaraman

**I. Call to Order**

a. 2:05 PM
b. Quorum met

**II. Adoption of the Agenda**

a. Meena motion to approve
b. Fran seconded
c. Approved

**III. August Minutes Review and Approval**

a. Fran approved
b. Meena & Olateju seconded
c. Approved

**IV. Presentation**

**A. Maryland Primary Care Program (MDPCP)**

*Chad Perman, Executive Director, MDPCP Management Office*

a. Overview of MDPCP
   i. 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.
   ii. Approximately $200M annually in Federal dollars is sent directly to primary care practices for patient care.

iii. Foundation to any new Health Care Model agreement with federal government

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

c. Key Areas of Public Health Overlap
   1. Developed key tools for Public Health Infrastructure - Respiratory Disease Response for PCPs
      a. Higher COVID-19 vaccination rates in all study months (Dec 2020 - March 2022)
      b. 12.4% higher rate of COVID-19 vaccine boosters
      c. 7.6% lower rate of overall COVID-19 cases
      d. 12% lower inpatient admission rate attributed to COVID-19
      e. 27% lower death rate attributed to COVID-19
   2. Health Equity Supports
      a. Specifically highlighted was one of the MDPCP's main levers for practices to address health equity, the Health Equity Advancement Resource and Transformation (HEART) payment
      b. HEART payment is an innovative payment for primary care, and it provides additional funds to practices to support beneficiaries who have high medical complexity and live in an area of high social deprivation.
      c. The idea is to identify this group of individuals who have both complex medical and social needs, and

provide funds to practices to directly address these needs

d. Since its inception in 2022, HEART has allowed practices to accomplish really effective partnerships, linkages, and provision of support for their patients around social needs. You can see some examples on the slide here, and these are just 3 of many examples of what practices have been able to do with this payment:
e. Partnership with a local farm co-op to deliver packages with fresh produce for beneficiaries with food insecurity
f. 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

3. Population Health Data for Primary Care
4. Behavioral Health Integration in MDPCP
    a. Reached milestone of over 1,000,000 MDPCP beneficiaries screened for risky alcohol use and illicit substance use through Screening and Brief Intervention and Referral to Treatment (SBIRT)
    b. 338 practices implemented SBIRT
    c. 100% of practices report integrating behavioral health services
    d. Medications for opioid use disorder (MOUD) implementation began in 2024
    e. Hot Spots -
    f. High MOUD Treatment Need and Low Prescriber Availability: Montgomery, Prince George's, Anne Arundel, Frederick, Washington, and Baltimore counties.
    g. Moderate MOUD Treatment Need and Minimal Prescriber Availability: Kent, Queen Anne's, Dorchester, Charles, and Worcester counties.

d. WHAT NEXT

- Future State - Advancing Primary Care and Public Health Integration

- States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model; Press Release)
  - Seeking stakeholder input through TACs
- MDPCP continues and AHEAD may allow us to extend program well into the future
  - 2024 will be jointly focused on exploring the future of the program, as well as continuing the current program in alignment with 2024 priorities

a. Q&A
   i. Jean - Can you explain in greater detail the inclusion of medicaid by 2025
      1. Answer: the details are still be developed but it will be in 2 phases
      2. Health equity comment about next steps: Answer: Health equity work stream description would be useful; more to come
   ii. Meena - potential for expansion of behavioral health integration. eg the various behavioral health issues. SUD, Alcohol.
      Answer: We are open to expansion and yes, alcohol is included
   iii. Fran
      1. sharing personal experience of encounters with primary care providers engagement with patients demonstrating use of recommended screening/surveillance prompts; is there training that goes on to improve skills of providers with respect to provider patients engagement.
      2. How is PCP working around addressing reach
      Answer: (Need to bring Clinical Transformation Organizations/ MCOs // Hospital Pop Health Leads together)
      3. What strategy is underway to increase primary care capacity in the state
      Answer: We came up with Equip Primary to address workforce and reach.
   iv. Roselie Bright

1. with respects to the MDPCP work on respiratory health, Suggests provider talk to patients about cleaning their air

v. Maura Rossman
1. are there efforts to deliver care at the home. eg. patients with contagious disease that would be high risk comin into health clinics that is most times crowded
Answer: use of telemedicine; use of Visiting Nurses program: what about growing the work force. Some has that as their business model
Answer: Considering applying to CMS for some innovations; Workforce training programs need to be reviewed to see how to add to the needed workforce

vi. Boris
1. Knowing that most times the PCP spend more time treating diseases than prevention, what should the CoPH be looking at with respect to addressing those issues
2. Answer: Integration of multidisciplinary profession into the model long term so that they will know what is in it for them.

vii. Meenna
1. What are we doing with GME, AHAB, which is a pipeline that addresses workforce issues

viii. DVK and Matt Levy asked about CTOs:
CTO – Data management and analysis - how can/can the role CTOs play be partnered with public health? How can we look at CTOs to help with sustainability for public health? Consider funding streams

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## V. Commission Updates

a. Commission Timeline
   i. Timeline is living document
   ii. Cadence and activity staying the same (not slowing down), using additional time to build out assessment
b. 2025 Meeting Dates
   i. January 23
   ii. February 20

iii. March 13
iv. April 03
v. May 01
vi. June 05
vii. July 10
viii. August 21
ix. September 11

c. Assessment Update
   i. Regularly meeting with Assessment Team (biweekly) to coordinate
   ii. Continuing to refine questions and respond to feedback from Commissioners and workgroups
   iii. Managing scope vs. timeline
   iv. Fidelity to the statute and goals
   v. Focus areas of Commission
   vi. Feasibility
d. Final Interim Report
   i. Template and instructions under development
   ii. Current timeline:
   iii. Oct. 21 - Workgroup report drafts due to Coordinators/Staff
   iv. Nov. 7 - Discuss and adopt report; staff will make modifications based on feedback (or see note below)
   v. Dec. 1 - Submit Final Interim Report on or before this date
   Decision Point
      - Do we schedule another meeting (virtual) in November to continue discussion of FIR?
         - Meena moved a motion to schedule another meeting in November after Nov 7, 2024 meeting
         - Fran seconded the motion
         - The commissioner approved
e. Site Visitation
   i. Oct 28, 2024: Baltimore city, MD (North central)
f. Assessment
   i. Framework
      1. Surveys: organizational and individual staff
      2. Key informant and stakeholder interviews
      3. Focus groups
      4. Site visits
   ii. University of Maryland, Morgan State University, and CDC Foundation working together to deliver on assessment scope of work
   iii. Convening assessment steering group to refine details

iv. Dushanka Kleinman, UMD emeritus professor, providing technical advising to Commission

g. Commission roster
   i. Sen. Kelly departed Senate, Senate President's Office will appoint new member
   ii. Waiting on Governor's office to fill urban local health officer position

**VI. Deep Dive: Governance & Organizational Capabilities**

*Fran Phillips, RN and Barbara Brookmyer, MD, MPH, Co-chairs*

Focus:

a. The governance and organizational capabilities of Maryland's governmental public health system
   i. Outline a broad scope of inquiry reflecting key aspects of our public health (PH) ecosystem:
      1. Maryland's unique model of shared state and local PH governance
      2. MDH, a State superagency combining public health, behavioral health and Medicaid
      3. CRISP, our sophisticated, accessible Health Information Exchange responsive to public health interests
      4. HSCRC which regulates hospital rates with the explicit goal of advancing health equity and health outcomes
   ii. Identify key topics of inquiry to be explored in order to describe the nature of PH governance and organizational capabilities
   iii. Evaluate data derived from the CoPH Assessment, Commission and Workgroup meetings, site visits and listening sessions to describe Maryland's PH governance and capabilities
   iv. Develop recommendations for the next steps necessary to improve PH governance and organizational capabilities

b. Membership
   i. Barbara Brookmyer, MD, MPH
   ii. Fran Phillips, RN, MHA
   iii. Meena Brewster, MD, MPH
   iv. Angela Cochran, MS
   v. Erica Drohan, CFA
   vi. Marie Flake, MPH
   vii. Joan Gelrud, MSN, CPHQ
   viii. Isis Gomes, MPA
   ix. Kathleen Hoke, JD
   x. Nilesh Kalyanaraman, MD
   xi. Maria Maguire, MD, MPP

xii. Matthew McConaughey, MPH
xiii. Maura Rossman, MD
xiv. Julie Cady-Reh, MS, MBA (until 3/24)
xv. Michelle Spencer, MS
xvi. Wendy Wolff, MPH
Support Staff:
xvii. Sarah Kolk, MPH (until 7/24)
xviii. Hawi Bekele Bengessa, BA
xix. Shane Hatchett, MS

c. Activities
   i. 9 meetings (1/8, 2/5, 2/26, 3/25, 4/22, 6/4, 6/24, 7/22, 8/26)
   ii. Attendance at Commission meetings, site visits and listening sessions
   iii. Outreach to other state agencies to speak to workgroup or inform the process
d. Experts Consulted
   i. Jon Kromm, HSCRC Executive Director
   ii. Mary Bearden, Sr. Counsel at Office of the Attorney General
   iii. Indiana Department of Health staff
   iv. Speakers at Commission meetings
   v. Participants at Site Visits and Listening Sessions
e. Resources Examined
   i. Network for Public Health Law
   ii. Public Health Accreditation Board
   iii. National Academy for State Health Policy
   iv. Bipartisan Policy Center
   v. Centers for Disease Control and Prevention (CDC)
   vi. Peer states: Washington, Colorado, Tennessee, Indiana
   vii. Peer reviewed literature
f. Health Equity and Cross-cutting Themes
   i. Do Maryland's public health leaders have sufficient ongoing education, organizational support and accountability expectations to detect and act on prevailing cultural biases?
   ii. Do local boards of health, typically local county commissions /county councils make governance decisions representing the PH needs of all residents, including vulnerable local populations?
   iii. Is health equity enhanced in those states, unlike Maryland, which have a State board of health?
   iv. How is the role of the Commission on Health Equity evolving related to governance and organizational capabilities?
g. Cross-cutting Themes

i. To be further explored - how prevailing governance structures and practices impact specific areas such as:
    1. Infant and maternal mortality
    2. Preparedness
    3. Overdoses
    4. COVID-19

h. Initial Topics of Inquiry
    i. Topic #2: Leadership Training and Professional Development
        1. Is ongoing high quality leadership training available for senior PH officials?
        2. Can the orientation and onboarding of newly appointed PH leaders be improved?
        3. Are there established opportunities and resources for cross-jurisdictional exchange of evidence-based or promising practices?
        4. What role does Leadership Development and Professional Development play in personnel (organizational) stability and organizational competence at the state and local level?
    ii. Topic #3: Legal Considerations on Shared Governance
        1. Given Maryland's unique approach to shared governance, are there statutory or administrative ways to improve clear and consistent bilateral understanding regarding the authorities and responsibilities of the State and local health departments (LHDs)?
        2. Is there clarity and consistency in determining what office provides legal representation to LHDs, since they administer State statute, State regulation, local ordinances, and state/local procurement?
        3. What is the status of the agreement between the Maryland Department of the Environment (MDE) and LHDs regarding authorities, scope, policy support and technical assistance obligations under various regulations (OSDS COMAR 26.04.02, Water Supply COMAR 26.04.03, Well COMAR 26.04.04, Shared facilities COMAR 26.04.05, public bathing beaches COMAR 26.08.09)?
        4. Should amendments to State statute be considered to strengthen or modify emergency enforcement measures authorized under the Public Safety Act?
    iii. Topic #4: Policy Development and Implementation
        1. Are state and local PH leaders given opportunities to effectively and appropriately contribute to State policy development and implementation?

2. Are state and local PH leaders represented in the shaping and implementation of State environmental policy?
3. Do local PH leaders provide input to Medicaid and Behavioral Health Administration on policy matters directly impacting local public health?
4. Are there changes needed to the role and resources of the Maryland Association of County Health Officials (MACHO) to effectively represent and support local PH interests ?

iv. Topic #5: Accountability and Performance Management
1. Are current performance management systems for senior PH officials based on explicit and appropriate goals and metrics?
2. Are the goals and performance measures for state and local PH leaders and agencies synched with State health improvement goals?
3. Are local boards of health trained and supported in discharging their oversight responsibility to assess local PH leadership and agency performance?
4. How well do annual performance reviews of individual leaders and PHAB or other assessments of PH agencies capture relevant data and facilitate growth and quality improvement?
5. How might public health accreditation be used as a tool to address accountability and performance management?

v. Topic #6: Local Boards of Health
1. Are the minimal State requirements for local boards of health sufficient to provide effective governance to LHDs?
2. What inferences regarding local board composition can be derived from the experience of the two jurisdictions which have adopted ordinances specifying a board composition different from the local governing body?
3. Are state and local boards of health particularly useful? Unlike some states, Maryland has no State board of health. Likewise, there is no City board of health in Baltimore City, which does not participate in the State's shared PH governance model.

vi. Topic #7: Academic Partners
1. How might Maryland's highly regarded academic institutions which excel in public health expertise become consistently engaged consultants to state and local PH leaders and boards of health?

2. How could the development of an Academic Health Department relationship enhance organizational competencies?

vii. Continued Exploration
1. Are there possible changes to PH governance that could facilitate more effective partnerships:
2. Between LHDs and MDE as previously noted?
3. Between LHDs and MDH's Behavioral Health Administration including clarifying the authority and responsibility of 'local behavioral health authorities.'
4. What responsibility and authority do LHDs possess with regard to quality concerns within acute or institutional care facilities?
5. As hospital-based population health units proliferate in Maryland's evolving hospital regulatory environment, are there legislative or administrative measures that could incent collaboration with PH, promote efficiencies and avoid duplication?

viii. Input Requested
1. We look forward to ongoing engagement with each Workgroup.
2. We are hoping for robust interview participation by key informants and look forward to analyzing the quantitative and qualitative findings of the Assessment.

ix. Focus Next 3-6 Months
1. Continue monthly meetings with invited speakers and…
2. Adapt our work to input received from other Workgroups and actively comment on Deep Dives presented by other Workgroups
3. Consider the role of governance and organizational capabilities with respect to effectively responding to the cross-cutting themes (preparedness, COVID-19, maternal and infant mortality, overdoses)
4. Closely review findings of the assessments for direction regarding governance issues

x. Questions?
Boris:
1. We can recreate the governace or organizational capabilities system and or structure, how can we restrategize
Answer: We can support them and or do statutory cleanup

Roselie:

1. Most times LHD have a different opinion from the state or federal, how is that addressed? who is the authority
   Answer: This is what we are looking to getting clarified on using the question the comm and pub engagement asked on who is the authority

Matthew Levy

1. Lack of uniformity within the department and the complexity and understanding of who is working for who etc
   Answer: Is what the training is to address

**VII. Announcement**

a. Next CoPh general meeting: Oct 3, 2024
b. Baltimore city site visitation/public listening session: Oct 28, 2024
c. Interim report due: Oct 21, 2024

VIII. Adjournment

a. Meena motion to adjourn
b. Jean seconded
c. Approved
d. Adjourned 5:00 PM

**Carolyn Nganga-Good, DrPH, RN, MS, CPH,** is an advanced public health nurse administrator with extensive nursing and public health management experience. Dr. Nganga-Good is a Deputy Director at the U.S. Department of Health and Human Services, Health Resources Services Administration (HRSA), Health Systems Bureau. She previously worked at HRSA's National Practitioner Data Bank and the Division of Nursing and Public Health. Before her federal service, she worked at the Baltimore City Health Department, Bureau of HIV/STD Services and prior to transitioning to public health, she worked as a critical care nurse.

She has a Doctorate Degree in Public Health from Morgan State University, a Master of Science in community/ public health nursing and a Bachelor of Science in nursing from the University of Maryland, and an associate degree in nursing from Baltimore City Community College. She was one of the 25 national Robert Wood Johnson Foundation Public Health Nurse Leader Program Scholars (2015-2017) representing Maryland and led a Maryland public health nursing workforce study. She is certified in public health and a certified HeartMath Resilience Advantage trainer.

She serves on several boards including the Maryland Nursing Workforce Center Advisory Board, Association of Public Health Nurses Board, and the American Red Cross National Nursing Committee as the Vice Chair and Chair of the International Services Committee.

Dr. Crystal DeVance-Wilson, PhD, MBA, PHCNS-BC, 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 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. She is the Vice-Chair of the UMSON Universities at Shady Grove department. Dr. DeVance-Wilson is also the Director of the Maryland Nursing Workforce Center (MNWC) where she succeeded Dr. Rebecca Wiseman, the founding director of the Center. She is a member of several national organizations including the Association for Public Health Nurse Educators (ACHNE), American Public Health Association (APHA) and Sigma Theta Tau (STT). As a member she has served on committees, delivered podium and poster presentations, and collaborated on publications. Dr. DeVance-Wilson has also held leadership positions in several community organizations including Chair of the Montgomery County Commission on Health. Dr. DeVance-Wilson's research interests include Black men's health, health policy, health disparities and the nursing workforce.

**Ann T. Kellogg, Ph.D. Bio**
Director of Reporting Services, Maryland Longitudinal Data System Center and Maryland Higher Education Commission
Ann Kellogg's work at the MLDSC 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. Her work at Maryland Higher Education Commission (MHEC) focuses on developing data collections and completing research studies or other special projects. Prior to joining the MLDSC/MHEC in 2017, Kellogg focused her career in postsecondary education serving in instructional and administrative positions. Kellogg received her Ph.D. in Public Policy from the University of Maryland, Baltimore County.