MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, February 1, 2024 | 2:00 PM - 5:00 PM
Baltimore County Dept of Health | Virtual

Commissioners present in person or virtually:
Camille Blake Fall
Gregory W. Branch
Christopher Brandt
Meenakshi Brewster
Nilesh Kalyanaraman
Boris Lushniak
Olutosin Olateju
Fran Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg

Commissioners absent:
Heather Bagnall
Jean Drummond
Ariana Kelly
Alyssa Lord

Workgroup members present in person (others joining virtually):
Stephanie Ajuzie
Sanmi Areola
Cynthia Baur
Craig Behm
Roselie Bright
Barbara Brookmyer
Julie Cady-Reh
Brian Castrucci
Saniya Chaudhry
Angela Cochran
Kassie Coulson
Kisha Davis
Jennifer Dixon Cravens
Negin Fouladi
Tonii Gedin
Joan Gelrud
Isis Gomes
Christina Gray
Stephanie Harper
Roger Harrell
Rebecca Jones
Michelle Kong
Maggie Kunz
Vanessa Lamers
Sylvette La Touche-Howard
Lisa Nelson
Isabel Rodriguez
Chloe Scott
Gena Spear
Earl Stoner
Bill Webb
Randi Woods

I. **Call to Order**
   a. Presiding co-chair M. Brewster called meeting to order. All consent to be recorded by remaining on call. Further questions or comments by workgroup members can be sent to md.coph@maryland.gov.
   b. Commissioner Roll call – Quorum met

II. **Adoption of the Agenda**
   a. A motion was made to adopt February agenda.
   b. Agenda unanimously adopted

III. **January Minutes Review**
   a. A motion was made to approve the minutes from January 4, 2024 CoPH virtual public meeting; the motion was seconded.
      i. There were two name corrections mentioned and approved as amended.

IV. **Special Guests**
   a. In addition to presenters, Dr. Judy Monroe, Megan Roney from CDC Foundation were introduced

V. **New Business (Discussion/Motions)**
   a. Revised timeline for CoPH
      i. Meeting in Annapolis, Senate was pro forma, so meeting was hybrid. In attendance, Delegate Mark Chang (Appropriations Committee), a representative from Senator Kelly's office, Representatives from Maryland Health Resources Commission, Maryland Healthcare Commission, support staff, and 5 Commissioners attended. The participants presented concerns: timeline, funding staffing, timeline
         1. Timeline
            a. 3 proposed timelines for final report: as-is with report due December 2024; 6-month extension with final report due June 2025, 1-year extension with final report due December 2025. December 2025 proposed because a legislative session is not until 2026, so June 2025 deadline leaves a 6-month gap. A 6-month gap gives time to rally and gain support, however, there's the opportunity for the report to lose pertinence. A report would still be given December 2024 for the next legislative session, however, it would not be called the "final report."

b. A motion was made for June 2025 deadline; that motion was seconded.
    i. 9 ayes, 1 nay
    ii. Motion was carried

b. Public meeting regions/hosts
    i. Legislation requires 3 public meetings. 4 locations in different regions approved by commission (western MD – Washington County, Eastern Shore – Talbot County, central MD – Howard County, southern MD – St. Mary's County). Geographic representation is not a stipulation; this was something the co-chairs decided on. Commission may decide to do more but will need to take into account timeline and assessment period.
    ii. Last meeting, a suggestion for second central Maryland location due to concerns about representation: Baltimore City, Montgomery County, Prince George's County. All 3 health departments were interested; however, 2 options today based on feasibility from a timeline logistics perspective: Baltimore City and Montgomery County.
    iii. Montgomery County per 1 million residents: 40% white, split Latino, African American. Economic disparity (perceived as a rich county but a lot of poverty); many different languages represented. Health Department has experience with public meetings.
    iv. A motion was made for Commission to delegate to co-chairs to make decision; motion was seconded and granted unanimously.

c. Data and IT workgroup co-chair change
    i. Bill Webb has to step down; Matthew Levy offered to be a new co-chair.
    ii. A motion was made to adopt and seconded; motion granted unanimously.

VI. Presentation: Overview of Maryland's State Public Health Infrastructure (available on website)

Nilesh Kalyanaraman, MD, FACP Deputy Secretary of Public Health Services Maryland Department of Health

*Presenter introduced by B. Lushniak

a. About the Maryland Department of Health
b. Vision, Mission and Core Values
c. MD Dept of Health Org Chart
    i. Secretary Laura Herrera Scott oversees department with 5 different units with deputy secretaries

d. Leadership
    i. Maryland Health Secretary – Laura Herrera Scott
    ii. Public Health Services Administration Deputy Secretary – Nilesh Kalyanaraman
    iii. Development Disabilities Administration (DDA) Deputy Secretary – Marlana Hutchinson
    iv. Behavioral Health Administration (BHA) Deputy Secretary – Alyssa Lord
    v. Health Care Financing and Medicaid Administration Deputy Secretary – Ryan Moran
    vi. Operations Administration Deputy Secretary – Bryan Mroz
e. Capabilities of the Maryland Department of Health
f. Funding and Budget
    i. MDH 5-Year Trends
        1. 2024 $19.6B in funding (~1/3 of the state's budget)
    ii. MDH FY 2024 Appropriations
        1. Public Health Services FY 2024 Appropriations
    iii. Federal Stimulus and Dedicated Purpose Account
g. Public Health Services Administration
    i. About
    ii. Guiding Principles
    iii. Commitment to Equity
    iv. Operational Units
h. Local Health Departments
    i. About
    ii. Programs in Local Health Departments
i. Prevention and Health Promotion Administration
    i. PHPA Units
        1. Maternal and Child Health Bureau
            a. Programs
                i. Work is focused on how we are supporting families with young children and giving them the best start to life and improving their health.
        2. Environmental Health Bureau
            a. Programs (regulatory, programs focused on environmental effects on health, violence and injury prevention)
        3. Cancer and Chronic Disease Bureau
            a. Programs
                i. Cancer Prevention and Control

1. A lot of this work is focused on filling in in gaps in insurance, access, public health services
   - ii. Chronic Disease Prevention and Control
   - iii. Tobacco Prevention and Control
   - iv. Oral Health
   - v. Maryland Kidney Disease Program
4. Infectious Disease Epidemiology and Outbreak Response Bureau
   a. Does not include STIs/HIV/HBV/HCV
   b. Programs
5. Infection Disease Prevention and Health Services Bureau
   a. Programs

j. PHS Administration (mostly administered at state level)
   - i. Office of Preparedness and Response
     1. Programs
   - ii. Office of Health Care Quality
     1. Programs
   - iii. Office of the Chief Medical Examiner
     1. Programs
   - iv. Vital Statistics Administration
     1. Data currently only available as pdf. No dashboard
     2. Programs
   - v. Laboratories Administration
     1. Programs
   - vi. Office of Provider Engagement and Regulation
     1. Programs
        a. Office of the Prescription Drug Monitoring Program
        b. Office of Controlled Substances Administration
   - vii. Office of Population Health Improvement
     1. Programs
   - viii. State Anatomy Board
   - ix. Public Health Workforce & Infrastructure Office
     1. Priorities

k. Public Health Service Initiatives
   - i. MDH Accreditation by the Public Health Accreditation Board
   - ii. Public Health Infrastructure Grant
   - iii. Public Health Workforce Development

1. Workforce Development Internship Program

iv. Data Modernization: Goals and Associated Outcomes

1. Public Health Datasets, Applications & Systems

l. Questions from Group

i. B. Lushniak: How to define workforce? To LHDs, what are your problem areas (recruiting, retaining, expertise)? There was ample discussion regarding recruiting, retaining, and expertise.

1. A participant proposed SWOT analysis, comparing with other states, and addressing it at another meeting.
2. N. Kalyanaraman: Currently going through state assessments, will have measures and comparisons to other state as part of state health improvement plan in April or May. MD doesn't have good state data about healthcare workforce. VA provides good model for how to look at trends. Office of Population Health improvement bringing together stakeholders to develop picture of healthcare workforce.
3. F. Phillips: Other things going on a MDH that are germane to PH but not part of PHPA, like behavioral health. There are health policy decisions made outside MDH. Health Services Cost Review Commission

VII. Break

VIII. Presentation: Public Health System Assessments and Transformation Approaches (available on website)

Reena Chudgar, MPH Senior Director, Public Health Systems and Services Public Health Accreditation Board
Jessica Solomon Fisher, MCP Chief Operating Officer Public Health Accreditation Board

*Guests introduced by O. Olateju

a. About PHAB

i. 1 of 3 national partners funded to support the public health infrastructure grant work.

b. Foundation Setting around Public Health Transformation

i. Foundational Public Health Services (this adheres to national model)

1. Foundational Areas
2. Foundational Capabilities

3. One commissioner noted behavioral health is currently not considered a foundation of public health services, but that might need to be reconsidered services but that might need to be reconsidered.
    a. J. Solomon Fisher: Model meant to be broad to cover all health departments, so there is variation and more can be included on a state level. We do not rank states
4. This framework embedded in the field at a national level, and more than a dozen states have adopted this framework to try to better define what governmental public health ought to be
5. Another commissioner noted 21st century learning community with the 18 states that are doing this work. In 2021, de Beaumont Foundation, put out workforce shortages nationally. Found that for foundational capabilities *only,* they were 80,000 workers short. These were pre-covid numbers and did not account for the rest of that model
6. This is the framework against which the commission can make recommendations for foundational capabilities and areas

ii. Accreditation and Recognition
1. During accreditation process, departments have the framework for communicating what public health is and what it does
2. Assures that all parts and whole of the departments are working to deliver comprehensive public health services based on national peer-reviewed standards
3. Quality improvement process
4. Identifies areas for continued improvement
5. 12 of 24 LHDs in MD are accredited
6. In many states, accreditation is a key driver in transformation

c. 21st Century (21C) Approaches to Transformation
i. PHAB 21st Century Learning Community (18 states)
1. Statewide systems including state health department, local health departments, other public health-related organizations
2. These states are implementing work similar to Commission's work

3. Working in various ways to build the foundation of public health services
4. Learn, share, contribute, and support each other

ii. Systems Approach to Transformation
1. Begins with developing a vision and adopting a framework (FPHS Model)
2. Begins with assessment of current foundational public health services and cost. If there is a gap, that may go to legislators as a funding request
3. Public Health Infrastructure Grant
a. From CDC. Over $5B (for 5 years) in flexible funding to support infrastructure to support all the things that don't usually get supported in public health
b. Maryland a recipient as well as Baltimore City directly. 40% of funding meant to go to other LHDs.

d. Assessment Tools
i. PHAB Tools for Transformation
1. PHAB FPHS Capacity and Cost Assessment
a. Found it's best to assess state-wide, not just at individual health department level
2. PHAB Readiness Assessment
3. Public Health Workforce Calculator
a. Currently, limitations on health department size to use tool: Depts that serve a population of under 500,000
b. B. Lushniak: Do we know if any MD LHDs have used this calculator?
c. How do you map Maryland's activities to the operational definitions that exist? What else are you looking to assess?
4. 21C Examples
a. Missouri, Wisconsin, Ohio
b. Oregon and Washington

e. Recommended Approaches for Assessment
i. Statewide Capacity and Cost Assessment
ii. Considerations for Recommendations

f. PHAB Supports & Q&A
i. Question O. Olateju: Has Ohio's mandatory accreditation been effective? R. Chudgar: Ohio has a mandate for PHAB

accreditation. Currently working on impact evaluation, so will have a better idea in June when that's completed.

ii. Question from M. Rossman: Maryland currently undergoing reaccreditation. Are these tools being utilized during this process?

1. R. Chudgar: Readiness assessment would not have been available for accreditation application

IX. Workgroup Updates

a. General

i. CDC Foundation collaborating with MACHO to provide funding for support staff and support staff directly from CDC Foundation

1. UMD and Morgan State University are mobilizing to help with student interns

b. Workgroups

i. Communications & Public Engagement

1. N. Rochester: First meeting Jan 25, introductions and discussion around reasons for joining workgroup. Trust, dis/mistrust. Messenger is as important as message. Meet people where they are. Collaboration, importance of bidirectional communication, accessible language, utilizing other methods of distribution like social media and texting, relevance of information (accurate, culturally relevant). Public engagement: shift in power dynamics that currently exist between community and providers and that everyone is part of public health. Timing important, not waiting until crisis. Reaching populations such as seniors, disabled, those without internet access, and those with language barriers

ii. Data & Information Technology

1. C. Brandt: Met Jan 24; discussed data needs and possible barriers; identified need for information on data systems enhancements, deciding what sort of assessment to conduct; integration: public health data system as well as clinical delivery data system; data to action: what to do with it; funding: staffing for assessment work, how to deliver services; capacity and workforce development; equity, delivery; legal barriers

iii. Funding

1. L. Polsky: Overview of PH in MD, highlighted funding issues structurally across the nation (compared to other countries, US spends the lowest on public health prevention); discussion about how MDH and LHDs are funded: often through year-long, restrictive grants, which does not provide enough time for planning or effective use; LHDs often provide the clinical services that the private sector cannot generate profit from. The revenue received does not match the cost of providing the services; core funding: a shared responsibility between state and counties, heavily contingent on broader economy and restrictive, therefore not dependable; community health benefit dollars: preliminary discussion about how funds could be better used to address social determinants of health across the state, these funds are predictable, recession proof, available across the state; action items for members: research add'l areas of public health funding that may be used in other states and possibly other experts in the field

iv. Governance & Organizational Capabilities
    1. F. Phillips: Met in January, meeting again early February and then will have regular meetings; will be looking at quantitative measures, many qualitative measures around assessment of governance and organization. Clarification: this is not organizational administration in a health department, rather focusing on local and state health department org chart; would like to conduct interviews and would like ideas about surveys, about how to structure qualitative measures, would like input from commission on who to talk to. Recommendations from workgroup won't likely be as simple as checking a box

v. Workforce
    1. B. Lushniak: Met on Jan 23, will meet the first Tuesday of every month; discussion on defining public health workforce; should recommendations be achievable or aspirational since legislators need also need to be able to take action; considerations of funding since it's needed for hiring; hiring process: hiring based on degrees, experience level, needs?; quality, adequacy of staffing workforce; will be

examining Public Health Workforce and Needs Survey from de Beaumont; action items for workgroup members to find other useful surveys and datasets

X. Announcements

a. Next meeting: March 7, 2024, 2-5PM at Baltimore County Dept of Health with virtual option

XI. Adjournment

a. Meeting was adjourned at 5:02pm upon motion of O. Olateju, motion was seconded