Thursday, March 7, 2024 | 2:00 PM - 5:00 PM
Baltimore County Dept of Health | Virtual

Meeting Minutes

Commissioners present in person or virtually:
Camille Blake Fall
Christopher Brandt
Meenakshi Brewster
Alyssa Lord
Boris Lushniak
Oluwatosin Olateju
Fran Phillips
Nicole Rochester
Maura Rossman
Michelle Spencer
Allen Twigg

Not present:
Heather Bagnall
Jean Drummond
Nilesh Kalyanaraman
Ariana Kelly

I. Call to Order

- Presiding Co-Chair Boris Lushniak called meeting to order at 2:17 PM.
- Agenda was summarized and a brief overview of the Commission on Public Health (CoPH) was given.
- Public comments are encouraged via email: md.coph@maryland.gov.
- Roll call, quorum met.

II. Adoption of the Agenda

- Motion to approve agenda by O. Olateju, seconded by F. Phillips.

III. Minutes Review and Approval

- Motion to approve by M. Rossman, seconded by C. Blake Fall.

IV. Presentation: CRISP State-Designated Health Information Exchange (HIE) - Overview and Services

Craig Behm, MBA - CEO, Chesapeake Regional Information System for our Patients (CRISP)

- Presenter introduced by O. Olateju.

- CRISP vision: To advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration.
- Collaboration and cooperation are key.
- Overview of history.
- Technology components: large amount of data input, linked, and pushed back out.
- Data quality as point for future discussion.
- C. Brandt: Any experience stratifying population data for interventions?
  - C. Behm: Example: Medicaid program for children with asthma. When child presented in ED with asthma, sent notification to health department.
  - C. Behm: Cannot give person-level data out but can look at opportunities at data level.
- F. Phillips: Percentages on slide?
  - C. Behm: Of 16.6 million pieces of data that came in during January, had race information on 95%.
- J. Cady-Reh: Why would diagnosis be lower in terms of completeness?
  - C. Behm: Not all sources can give data, but data may be available through other means. CRISP could get more detail if specific requested.
- Overview of CRISP services
  - C. Brandt: What about pharmacy data in population health reports?
    - C. Behm: Have CDS prescriptions, but don't have good pharmacy data.
- F. Phillips: CRISP was very helpful during pandemic with information about acute care utilization.
  - C. Behm: Speaks to governance and culture of CRISP as it evolved.
- CRISP is neutral convener to information across entities, e.g., immunization data between schools and MDH.
- C. Brandt: Used CRISP to push attendance data from schools in DC.
  - C. Behm: Worked with Medicaid agency in DC and public schools to take absenteeism data at the child-level and send it to Medicaid to see links to health.
  - No technical limitations from CRISP's perspective, about policy.
  - Can probabilistically match identities across data systems.
- CRISP powerful because of broad coverage and robust governance. Can create population level data to drive interventions and precisely track outcomes.
- F. Phillips: Could be used for harm reduction programs to follow-up with patients who have had non-fatal overdose events.
- Limitation of CRISP: Information derived from case-mixed data, so only people in hospital contributing.
- O. Olateju: Systems to prevent redundancies?
  - C. Behm: Linking to person levels enables dealing with duplicates.
  - C. Brandt: Every time hospital encounter, CRISP gets information about that patient.
- Social determinants of health: First focus on driving interoperability across system, then building tools to enable assessments and referrals. Technology is in place, now a policy and prioritization question.
  - Authorization capabilities for consent into social determinants treatments.
    - F. Phillips: Can you select into certain SDH treatments?
      - C. Behm: No, all in or all out.

        - C. Brandt: But mental health information is treated differently.
    - F. Phillips: What about reproductive health?
        - C. Behm: Do segment and redact sensitive codes for reproductive health.
- CRISP is neutral collaborator for the state. Aligned with current Total Cost of Care Model.
- Law passed to designate the health information exchange as the health data utility, acknowledging data needed to be shared bilaterally with local health departments.
- B. Lushniak: Where should Commission be going vis-a-vie CRISP?
    - C. Behm: As we establish strategic measures, would like Commission to give direction about both measures and the specific health care interventions they drive.
- CRISP can link other data too, like housing authority, SNAP enrollment. It's a question of the policy and deliberate thought about privacy.
    - C. Brandt: It's an area for public health leaders, not technology.
- M. Rossman: Need stronger links between health care and public health.
    - C. Behm: Some pockets of good work being done, but the question is about if there is a systemic approach and if it can be done population wide.
- N. Rochester: What categories currently used to describe race and ethnicity?
    - C. Behm: CRISP uses the seven federally designated categories, same as what hospital uses. Can follow up with more info. Would be a technology lift to expand, but a policy question to be asked.
- N. Rochester: Analysis by language?
    - C. Behm: Do not have a lot of language data.
    - M. Brewster: Because it is not standardized for input?
        - C. Behm: Not standardized, but also to get data, need to go back to sources CRISP is connected to and ask for it. Faster if global push for this.
- R. Bright: Monitor for unexpected rising trends?
    - C. Behm: No, currently don't do this. Of interest of this for the future, would be a great ask
- M. Brewster: Data from ambulatory/primary care?
    - C. Behm: Made progress here, part of Maryland Primary Care Program. MD only state with full image exchange. Should look at finding gaps in participation, emergent care is part of this.
    - M. Brewster: Can it be used in public health sector?
        - C. Behm: Surveillance is of interest, nervous about sample size, but have heard from leaders that something is better than nothing.

V. Presentation: Behavioral Health

Alyssa Lord, MA, MSc, Deputy Secretary of Behavioral Health, Maryland Department of Health

- Introduced by M. Brewster.
- Mapped out behavioral health continuum of care.

    - Translated back claims and utilization data for white space analysis - on website of Commission for Behavioral Access and Treatment.
    - Urgent and acute care is new pillar for department.
    - Meant to be fluid, individuals and families may enter and exit services at different points – about journey to wellness.
- Care is local, what care looks like across counties may look different. There are core tenants of programming but have left much to community partners.
- Expanding mobile crisis and stabilization.
- Considering vehicles to discharge individuals into community.
    - Opportunity to think about discharge at time of admission.
    - Thinking about housing and food insecurity in treatment and recovery.
- Policy and planning are focused on licensing and accreditation.
    - Looking at COMAR to consider how to bring new entrants into the market and how to build services off quality and outcomes.
    - Looking to expand team on licensing and monitoring.
- Partnering across MDH to make sure strategic plan alignd and is a whole-person, integrated model.
- Reviewed strategic priorities for next calendar year
- M. Brewster: Can you speak to organization of behavior health oversight services including prevention?
    - A. Lord: Behavioral health is part of public health intervention, requires partnership with local health departments and local boards of health to build sustainable continuum of care.
    - M. Brewster: Local health departments serve as chief health strategists for communities
- M. Rossman: Governance of behavioral health in Maryland?
    - A. Lord: Complex ecosystem, governance and infrastructure are different in each jurisdiction. More latitude needed before thinking about how to set up infrastructure and build sustainable provider networks to meet deliverables in continuum of care.
    - B. Lushniak: Part of Commission's work is to think about how we work toward it.
- R. Bright: Model for behavioral health in Norway that is proactive.
    - A. Lord: Highlights need for investment early in intervention and multi-stakeholder approach.
- F. Phillips: Hope behavioral health team will be open to key informant interviews and ecosystem mapping process to map state and local behavioral health constellation.

VI. Workgroup Updates

- B. Lushniak introduced presentations. Goal is to tabulate all data needs and coordinate asks to gather data.
- Communications and Public Engagement
    - Presented by Tonii Gedin and Sylvette La Touche-Howard
    - Still don't have data about who is trusted and credible.
    - Data needs from local and state health departments

        - Communication capacity
        - Public engagement capacity
            - Capacity for bidirectional community engagement
            - Culture competence
    - Data needs from public
        - Health literacy
        - Attitudes, perceptions, and preferences
            - Preferred channels
            - Trusted messengers
    - Challenges
        - Survey fatigue
            - C. Brandt: Other groups will have surveys, too.
        - Time constraints
        - Staffing
        - Lack of incentives
        - Privacy
        - Trust – Theme in workgroup conversations.
        - Technological barriers
- Data and Information Technology
    - Presented by Rachel Bouduani on behalf of Jay Atanda and Matthew Levy
    - MDH conducted assessment of state data needs, Workgroup plans to continue this assessment at local health department level.
        - Used evaluation framework and self-assessment tools.
    - Data needs
        - Data systems enhancements and transformation
        - Integrate public health data systems
        - Open data
        - Data to action
    - Barriers
        - Funding for data needs across local health departments
        - Capacity – workforce
        - Equity
        - Local barriers – data sharing
    - Crafted vision statements and goals. Breaking goals down into measurable action items.
- Funding
    - Presented by Larry Polsky
    - Core funding formula has not been revamped in over a century – ideas to modernize.
    - Payment issues with local and state health departments in terms of grants, billing for clinical services – particularly for populations covered.
    - For future meetings
        - Is there a place for public health funding in next iteration of CMS waiver to address downstream health care outcomes?
        - Community benefit dollars: Meeting with COO of Maryland Hospital Association and Johns Hopkins researchers looking into other states.

- Future research: Novel ways other states fund public health sector and other countries distribute funding between clinical care, medical care, and public health.

- Governance and Organizational Capabilities
  - Presented by Fran Phillips
  - Fundamental questions about scope.
    - Broader scope: Behavioral health, HSCRC, Maryland Department of Environment.
    - Maryland unique, hard to benchmark against other states.
      - MDH is superagency
      - Governance "largely shared" between state and local
      - CRISP
      - Outsized disparities that are persistent
  - Data needs – Mostly lend themselves to qualitative questions.
    - Law and regulations governing state and local public health - Empirical, have resource for this.
    - Five core governing authorities – Assessing using key informant interviews.
    - State and local relationship
    - Leadership – Demographics, qualifications, performance, underlying culture, untapped opportunities.
    - How governance structure impacts equity and quality
  - Need support meeting qualitative needs in terms of design, analysis, dealing with sensitive topics.
  - Posed questions for other workgroups.
- Workforce
  - Presented by Brian Castrucci
  - Will be a lift to duplicate assessment work done in Indiana.
  - Assessment plan: Profile survey with participation from all local health departments.
    - Accelerate 2024 PH WINS
    - Complete qualitative interviews in all local health departments.
- Group discussion
  - O. Olateju: For Workforce: Interns from Coppin and Morgan State too?
    - B. Castrucci: Yes, all interns.
  - M. Rossman: For Workforce: Surveying centralized organizations like MDH and MDH, Boards of Health?
    - B. Castrucci: For individual surveys, will focus on local health departments. MDH already participated in state level surveys; state-wide we have good data.
  - F. Phillips: For Data and IT: Cannot overlook internal data systems related to fiscal management, procurement, HR, grants.
    - Lack of interoperability is big problem.
    - Maybe falls within Governance and Organizational Capabilities. Could be an area for shared responsibility between workgroups.
  - F. Phillips: Suggest presentation by HSCRC for Commission.

        - B. Lushniak: Agree, on list for upcoming meeting
    - Commission leadership will think about how these data needs can be intertwined and coordinated.
    - Keep in mind: Indiana Report includes goals for each workgroup, followed by recommendations to achieve those goals, and actions to complete those recommendations.
- CDC Foundation and Support for Workgroups
    - All 5 workgroups have CDC Foundation-supported Workgroup Coordinator.
    - Hopeful to soon onboard a Chief of Staff to align work of Coordinators.

VII. Old Business

- Five LHD site visits followed by regional public listening sessions
    - St. Mary's County (SoMD): April 16th [starting at 11am]
    - Washington County (Western MD): May TBD
    - Montgomery County (Central MD): June 4
    - Howard County (Central MD): June 13
    - Talbot County (Eastern Shore): tentatively July 2

VIII. New Business

- Indiana site visit
    - 9 individuals representing Maryland Commission.
    - Met with individuals from IN Governor's Public Health Commission, Indiana University Fairbanks School of Public Health (conducted assessment), and those working on implementation of recommendations.
    - Motivation for Maryland comes from different place than Indiana. Maryland can leverage our strengths and focus on unique challenges.
- Commission leadership been updating political leadership in state.
- Workgroup leadership changes
    - Workforce Workgroup: Bob Stephens retiring from Garret County, proposing Susan Doyle, Carroll County Health Officer, replace on workgroup.
    - Funding Workgroup: Gregory Branch no longer Baltimore County Health Officer and co-chair of Funding Workgroup, proposing Roger Harrel, Dorchester County Health Officer, replace on workgroup
    - F. Phillips: Representation from MDH on Workgroups?
        - M. Brewster: Representation on all workgroups
    - Motion to approve new workgroup co-chairs by C. Brandt, F. Phillips seconded – Unanimously approved.

IX. Announcements

- April 4, 2024, 2:00 - 5:00 PM
- Location to be determined

X. Adjourn

- Motion to adjourn by M. Brewster, F. Phillips seconded – Unanimously approved at 4:57 PM.