MARYLAND COMMISSION ON PUBLIC HEALTH

May 2, 2024 | 2:00 – 5:00 PM EDT
Baltimore County Department of Health (Hybrid) | 6401 York Rd, Baltimore, MD 21212

Meeting Minutes

Attendees:

1. Camille Blake Fall
2. Heather Bagnall
3. Chris Brandt
4. Meenakshi Brewster
5. Boris Lushniak
6. Oluwatosin Olateju
7. Frances Phillips
8. Nicole Rochester
9. Michelle Spencer
10. Allen Twigg

I. Call to Order

a. 2:10 PM
b. Quorum met

II. Adoption of the Agenda

a. Fran Phillips motion to approve
b. Boris Lushniak seconded
c. Approved

III. April Minutes Review and Approval

a. Camille Blake Fall motion to adopt
b. Michelle Spencer seconded
c. Approved

IV. Commission Updates

a. Site visits and listening sessions
    i. Site visit to St Mary's County
        1. Highlighted issues around accessing care in southern, rural Maryland
        2. County health department team write suggestions, helpful for workgroups
    ii. Southern Maryland listening session
        1. 3 speakers
        2. Launched online comment form
        3. In person participation includes presentation with background on Commission

4. Looking for ways to encourage more people to participant
    a. Considering ways for people to call in and give verbal asynchronous feedback
    b. Outreach to community organizations, flyers

iii. Next site visit in Washington County on May 23
1. RSVP form will be sent to Commissioners and Workgroup Coordinators
2. Listening session in Hagerstown, MD from 5:00 – 6:00 PM
3. Interested in focusing on behavior health its intersection with law enforcement and diversion

iv. Comments from listening sessions will feed into qualitative analysis
v. New dates for Montgomery County and Talbot County site visits and listening sessions
vi. June 13 events are in Howard County – final details coming
vii. Baltimore City not currently on list, open to hosting in later August or September
viii. Discussion
1. Encourage people involved in Commission to attend site visit, very insightful into strengths and challenges of local public health
2. Setting for Southern Maryland listening session was good and those who spoke were passionate
3. Work with Washington County on strategy for communications for advertising
4. Outreach to co-chairs of Communications and Public Engagement workgroup – been working on this topic
5. Connect with people who already engage in community groups to help promote
6. Consider outreach at to county fairs or local events already happening during the summer – enable people to give feedback at that event (tabling)

ix. Motion to add Baltimore City site visit and public listening session by Nicole Rochester
1. Seconded by Tosin Olateju
2. Approved
3. Will move forward communicating plan with Baltimore City Health Department

b. Commission Timeline
i. Timeline is living document
ii. Cadence and activity staying the same (not slowing down), using additional time to build out assessment

iii. Three activity types concurrently happening across timeline
    1. Assessment
    2. System engagement (Guest speakers, site visits)
    3. Public engagement (Listening sessions)
iv. Plan for assessment to kick off in July/August 2024
v. Beginning in September 2024, deeper dives into workgroups
    1. Workgroups give Commission a sense about where this topic is headed and get their feedback
    2. Bridge assessment and recommendations
vi. Interim report due December 2024
vii. Wrap assessment in January 2025
    1. PH WINS data will be available in March 2025
viii. March 2025 is pivot: shift from information intake to imagining future
ix. Workgroups begin presenting recommendations in April 2025
x. July – August 2025
    1. Revising of report drafts
    2. 30-day public comment period
xi. Commission work concludes Oct 1, 2025; will be opportunities to stay engaged after, but Commission or Workgroups not required to meet
xii. Will send timeline out to Commissioners and request feedback
xiii. Discussion
    1. Local health officers in position to help with system engagement and public engagement
        a. Opportunities to engage via MACHO and MaCO
        b. Engage County Commissioners and elected officials
    2. PHPA has connections across local governments

c. Progress report and look ahead
    i. Legislation requires Commission to look at specific items – workgroups need to be aware of these
d. Assessment
    i. Framework
        1. Surveys: organizational and individual staff
        2. Key informant 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

e. 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

V. Presentation: MDH Office of Minority Health and Health Disparities (MHHD), MDH Population Health Transformation Advisory Committee, & 2023 MHHD Annual Report Findings

Camille Blake Fall, JD
Director, Office of Minority Health and Health Disparities
Maryland Department of Health

a. Question to think about: What is next after we have all the data we need about disparities? Don't want to get stuck in assessment.
b. Office of Minority Health and Health Disparities (MHHD) key activities include:
   i. Data collection, publication, and making meaning of that data
   ii. Advocating on issues that keep certain communities underserved
   iii. Work with PHPA on health promotion and disease prevention
   iv. Foster public-private partnerships
   v. Assist on equity priority setting and equity policies
c. Discussion about working definitions of health equity
   i. Healthy People 2030
   ii. Cultural sensitivity as component
   iii. Quality imperative – execute on activities we already know work to bring to bottom to the middle and raise the average
   iv. Focus on marginalized populations, while still eye on population level
d. MHHD activities
   i. Maryland Commission on Health Equity (MCHE)
      1. Developing framework for AHEAD
   ii. Grant programs
   iii. Department-wide equity assessment
   iv. Practices to address structural racism – office looking to upstream drivers
      1. Distinction between social determinants of health and health-related social needs
   v. Align work of MHHD with MDH priorities
      1. Opportunities to learn from local health departments

vi. Focus on health care workforce – particularly, underrepresentation of BIPOC behavioral health workers

e. Future of MHHD
   i. MDH equity steering committee charged to bring equity into every policy and program
   ii. Embedding equity into budgets
f. Population Health Transformation Advisory Committee (P-TAC)
   i. One of three committees convened to help MDH Secretary and HSCRC think about how to draft AHEAD application
   ii. Set equity targets and measures aligned with CMS
   iii. MCHE will be vehicle for each and state required equity plan,
   iv. Consideration: People in some communities may be hesitant to share health and social needs information, need to build trust
   v. Discussion
      1. Encourage focus on measurable goals
         a. "Both and" – yes, and MHHD here to keep centered on social needs
         b. What we are doing currently is not working, so must do more
g. Implications for public policy development: consider which factors matter and in what order
h. Discussion
   i. Where is data from recent initiatives?
      1. Website has 2023 annual report
      2. Secretary of Health creating databases public can utilize on opioid use
   ii. Current threats to equity work (political climate, universities eliminating programs that support minority health care workers)
      1. Can't only be moral imperative to diversify the workforce and treat everyone equitably
      2. Make business case for why healthier communities are a good economic investment

VI. Presentation: Collaboration Between Public Health and Healthcare Delivery

Chelsea Cipriano
Managing Director of the Common Health Coalition

a. Common Health Coalition came out of innovations in partnerships during COVID-19
b. Started with intent to make recommendations for how to advance collaboration between health care and public health
c. Four areas of focus (CARE)
   i. Coordination between health care and public health

ii. Always-on emergency preparedness
iii. Real-time disease detection
iv. Exchange of data

d. Six commitments to drive action within 1-2 years
    i. That timeline means focus on state and local level
    ii. Common Health Compendium on website shows examples of these commitments in action
e. Future resources include webinars and templates
f. Discussion
    i. What have you been seeing around country related to collaboration between health care delivery systems and governmental health departments?
        1. Equity: building metrics into outcomes, work with health care to learn what they are seeing in clinic setting, bi-directional data sharing
        2. If health care not seeing what is done with data they share, doesn't incentivize sharing
            a. COVID-19 dashboards helped change this
        3. Situational data exchange
    ii. Challenges amplifying success – H ow to work with surrogates in community to build trust and elevate successes to get more buy-in?
        1. Let organizations on the ground and community leaders do their own work with your resources and information
        2. Asking these leaders what they need from us
        3. Ex: NYC: Misinformation Response Unit
    iii. Communication & Public Engagement and Data & IT workgroup themes throughout presentation

VII. Discussion: Vision for Maryland's Public Health System

a. What are the vestiges of colonialism in existing systems that we are not aware of?
    i. Local Boards of Health are elected officials, may not be representative of populations in those areas
    ii. How past is ingrained in how public health system is organized
b. Equity must rise to the top, it is *the* priority for the future
c. Public health system is mental model and is too confining – instead, a health ecosystem
    i. Not just hospitals or traditional public health
    ii. Reexamine boundaries of public health
d. Longstanding social injustices in the way we do business of health means we must look at political determinants of health
    i. Opportunity to assess existing policies

e. Public and patient integration approach – need good understanding of what engagement means
    i. Need to include public in decision making – other countries do this, mandated by their system
f. Institute of Medicine reports: Future of Public Health and the Future of the Public's Health
    i. *Public's* health approach opened conversation to include all the players who have a relationship with health
g. Recommendations from governance about how to run public health system will impact other recommendations
    i. Will we have enough data to suggest we need to look at the system from a different perspective?
    ii. Governance workgroup assessment gets at questions of power dynamics and mental models
    iii. Recent meeting between GOC Workgroup and MDH attorney showed there is a fair amount of ambiguity in authority
    iv. Governance on population health done by HSCRC and MD Commission on Health Equity
h. Interplay of politics, policy, how public health is delivered, and how those influences outcomes in community
    i. Must be responsive to local communities – a strength of Maryland
    ii. How to both preserve this ability to respond to local demands and unique needs, and how to enhance it by giving localities tools and resources to respond and build partnerships
i. Challenge for health departments is consistency and time
    i. Lack of longitudinal approach to change
    ii. Partially about money – 60% grant funded
    iii. Opportunities for learning across jurisdictions and implementing what is working
j. Funding mechanisms
    i. Health departments work toward outcomes of grants; not flexibility in general funds to do innovative work
    ii. How to pay/reimburse community for their contributions to government and academic work
        1. Which communities have ability to access grant applications?
k. Keep eye on big picture items for Maryland and big picture approach for designing system for public's health

VIII. Workgroup Updates

a. Workforce

i. Opportunity to collaborate with Commission for Behavioral Health on workforce assessment

b. Governance and Organizational Capabilities
   i. Productive discussion with MDH Assistant Attorney General

c. Data and Information Technology
   i. Developed survey questions, now formatting
   ii. Developing key informant and focus group questions
   iii. Looking for state survey questions to then ask of local health departments, been in touch with MDH

d. Funding
   i. Heard from Maryland Hospital Association on community benefits spending – looking at private funding for public health

e. Communications and Public Engagement
   i. Two audiences for questions
      1. Public health agencies
      2. The public
   ii. Concerns around time – wanting to ask questions of community over the summer: Is it possible for questions of the public to be released sooner than rest of assessment questions?
   iii. Guest speakers: communications experts at agencies

IX. Adjournment
   a. Tosin Olateju motion to adjourn
   b. Michelle Spencer seconded
   c. Approved
   d. Adjourned 4:52 PM