MARYLAND COMMISSION ON PUBLIC HEALTH

Thursday, January 4, 2024 | 2:00 PM - 5:00 PM
Baltimore County Dept of Health | Virtual

Meeting Minutes

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

Commissioners absent:
Alyssa Lord

I. Call to Order

A. Presiding Co-Chair O.Olateju called meeting to order at 2:05pm. Quorum met and all consented to be recorded. The agenda was summarized and a brief overview of the Commission on Public Health (CoPH) was given. All materials available on website. Due process for meeting announcements was followed. Attendees were reminded that it was a public meeting and chat was not monitored; however public comments are encouraged via email: md.coph@maryland.gov
B. Roll call

II. Adoption of the Agenda

A. F.Phillips made motion to adopt the January agenda. Seconded by C.Brandt
B. Agenda unanimously adopted

III. Minutes Review and Approval

A. C.Brandt moved to approve the December 14, 2023 minutes of the CoPH virtual public meeting. Seconded by N.Rochester
    1. 1 abstention by C.Blake Fall (absent from that meeting)
    2. The motion was carried

IV. Presentation (virtual): Indiana's Process (available on website)

Judith Monroe, MD, FAAFP, President and CEO, CDC Foundation
Co-Chair, Indiana Governor's Commission on Public Health

*Presenter was introduced by M.Brewster

A. Indiana Public Health System Review

1. Published Dec 2020
2. Completed by Fairbanks School of Public Health
3. Funded by Fairbanks Foundation
    a. Philanthropy important in Indiana's ability to do this review and carry out the commission's tasks
4. Five sections
    a. Introduction, background, recent national frameworks
    b. Indiana's public health system and comparative states
    c. Literature review
    d. Qualitative data (stakeholder interviews)
    e. Recommendations

B. Executive Order 21-21: Established Governor's Public Health Commission (GPHC) in Aug 2021
    1. Charged with transforming public health
    2. Began Sep 2021 (last meeting June 2022)
        a. Had Fairbank Public Health System Report as a starting point
C. Two themes why commissioners joined
    1. Public health investments undergird vibrant communities
    2. Wanted Indiana to excel
D. Indiana public health ranked very low nationally
E. GPHC Reviewed Six Public Health Areas
    1. Workgroup/Policy leads designated for each of the six areas
    2. Policy leads conducted research and drafted recommendations for GPHC to review
F. State concretely supported Commission
    1. Indiana Department of Health (IDoH) charged by the governor to be support for Commission
        a. 4 key staff provided
    2. Provided project and admin support through Health Management Associates
    3. GPHC's Funding was almost even between state funding and Fairbanks Foundation
G. Commission established engagement plan
    1. Conducted over 30 stakeholder meetings over the course of a year
    2. Included online and social media
    3. Legislated engagement plan
    4. Press releases as part of communication plan and after each Commission meeting
    5. Fairbanks SPH conducted bootcamp for media to better understand public health
    6. 7 listening tours, each was summarized and reported out on
    7. IDoH had internal message plan to update staff and listening tours of those working in public health
    8. Slide decks for road shows
    9. Website that allowed public comments
        a. Over 480 collected and brought forward at Commission meetings
    10. ***Listen with intention***
H. Commission reviewed the many emerging public health reports in addition the initial Fairbanks report
I. Public Health Funding Findings
J. Public Health Funding Recommendations
K. Economic Case for Public Health

1. GlobalData and Eli Lilly - Study using local data and local material, reviewed cost of obesity to the state, presented to Commission and public

L. Transforming Public Health
    1. Commission and Governor recommendations
    2. Too much money too fast is not a good plan. Adjustment is needed for increased funding
M. Defining “good”: Foundational Public Health Services
N. Growing interest in FPHS model
    1. Very important model and commission used as part of recommendations in Indiana
O. What passed
    1. 1500% increase in funding for Local Health Departments (LHDs)
    2. Super important for Indiana to maintain local control
P. Accountability and transparency
    1. Everything recorded, everything public, public engagement. All available on website
    2. Reporting requirements by counties and LHDs
Q. Core Services: Spending requirements and caps
R. Health First Indiana
    1. Actual implementation
    2. Active July 1
S. Challenges and Opportunities
    1. Novel opportunity: Regional support teams embraced by local health departments
    2. Need to show return on investment to legislators (challenge)
T. Summer Activities
    1. Counties that opted in have received their funding (1/1/24)
    2. CDC Foundation provided technical assistance to local health departments and assisted in hiring staff
U. Funding Status
V. Final Thoughts and Lessons from Indiana
    1. Strong communication and engagement strategy and ongoing engagement, listening with intent, and willing to make changes along the way
    2. Listen to and help partners
    3. Be responsible with language used, be mindful of community
    4. Paper publications underway and will be shared
W. Questions
    1. Matching Funds
        a. Prior to commission – State funding to LHDs small, no match required
        b. After commission, matching had worked elsewhere in Indiana. Matching got buy-in
            i. For most counties, this increased funding, others did not
    2. Workforce and actions being implemented at state and local levels for public health
        a. Fairbanks School of Public Health and national experts provided expertise in public health workforce
        b. GPHC's workforce made recommendations for:
            i. Loan repayment
            ii. Also looked at workforce in healthcare not just public health

iii. Recommendations for pay raises and equalizing pay (some public health workers had not received raises in a decade)

c. Fairbanks put out detailed report on Indiana workforce that will serve as a tool

3. Getting consensus for recs from Commission
    a. A process. Lots of back and forth and gathering of more information
    b. In the end, the recs that were signed were the ones that everyone agreed on
4. Racial and socioeconomic breakdown in Indiana
    a. Dr. Monroe will get this information and share
5. Highest ROI spent on public health in Indiana and key public health metrics moved following investment
    a. KPIs from report
    b. Key topical areas:
        i. Opioid crisis
        ii. HIV from needle sharing
        iii. Infant mortality and childhood diseases; infant and maternal health issues
        iv. Mental health
    c. Dr. Monroe can come back with specific answer
6. What could hospital/payers be doing differently?
    a. Indiana Hospital Association adamant about supporting public health and prevention
    b. Important for healthcare and public health to work together
        i. Kaiser Permanent put together a group like this
    c. Supporting more of the team model of care; look closely where community benefit dollars are invested and are they being effectively used
    d. Cost-saving opportunities from hospitals teaming up with public health to get primary care out of the emergency rooms
7. Analysis of governance and infrastructure In Indiana vs smaller states; ideal size of LHDs; reporting mechanisms, who's holding accountable?
    a. LHD report to IDoH on KPIs twice a year
    b. No ideal size, home rule: counties want LHDs
    c. County was looking more at shared services and that's why regional support from IDoH has become a model because really small health departments are not able to provide all the services
    d. Goal of Indiana was for every resident to have access to core public health services
8. What to do with this information, how to apply to Maryland public health?
    a. Indiana model is not prescriptive. Maryland has its own needs and our experts will be figuring out what those are. When we figure that out, what can we take from Indiana's model which has been successful in their state?

V. Welcome Remarks - *John Olszewski, Jr., Baltimore County Executive; President, Maryland Association of Counties (MACo)*

*Guest was introduced by O.Olateju

VI. Break

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

Bob Stephens, MS, Health Officer, Garrett County
President, Maryland Association of County Health Officers (MACHO)

*Presenter was introduced by B.Lushniak

A. Governance – Hybrid
    1. How did Garret County become hybrid? How did they evolve?
        a. Some Local Boards of Health work on a Commissioner System, others use Code Home Rule, and others combine them, Garrett County included
        b. Seems to be the best model as cooperation btwn state and local and in both the state and local's best interest to have optimal public health
B. What do LHDs do?
C. 10 essential public health services
    1. 3 main categories: Assessment, Policy Development, Assurance → Equity
D. Common Local Public Health Focus Areas
E. Infectious Disease Control and Response
F. Environmental Health
    1. Secretary of Health (MDH), Secretary of Environment (MDE)
G. Access to Care
H. Advancing Health Equity: Address Social Determinants of Health
I. The Social Determinants of Health
    1. Work of commission: Informing the state what policies and programs need to be put in place to affect health factors and health outcomes
        a. Health outcomes is length of life and quality of life
J. Local health departments impact our lives every day
K. Communication and Public Engagement
L. Data and Information Technology
M. Funding
N. Workforce
    1. Maryland personnel system vs local personnel system
        a. Maryland – less admin burden
        b. Local – more flexible
O. Workforce – Staffing
P. Health Officers as Chief Health Strategists
Q. Garrett County Health Department FY 2023 Annual Report
R. Questions
    1. Do LHDs have partnerships with nonprofit groups?
        a. Garrett County works very closely with Community Action Agency
        b. Partnerships with agencies like Habitat for Humanity, local department of social services; every county probably has a different mix of the nonprofit they are working with who may have better opportunities to reach out to the community than the LHDs
    2. Are any community health workers employed in permanent positions and what percentage are employed vs funded by grants?
        a. Budgets heavily dependent on grant funding which supports workforce
        b. Challenge is getting sustainable funding to continue initiatives
            i. When relying on short term grants, that becomes a challenge
        c. Challenges when there's not enough money for everything (e.g. salaries but not research)

VIII. New Business

A. **Workgroup Co-Chairs and Members**: M.Brewster commended all workgroup members and co-chairs on the commission, referred them to the electronic membership roster previously emailed, and gave a brief on the Workgroup Co-Chair and Members Slate.

c. F.Phillips moved to approve that the commission adopts the workgroup co-chair and membership slate as presented. Seconded by G.Branch.

d. Questions and Discussions:

i. What is the plan for workgroups? Are there specific questions that will be developed for the workgroups?

Workgroups meet separately. Background research (data gathering and analysis), look at what is already being done, workgroup members use their expertise to devise questions based on Maryland's actual needs since there isn't any one solution that will work for all. It would be more of a partnership btwn the CoPH co-chairs and workgroup co-chairs so we are not being too prescriptive. We will need to think outside the box.

i. Is there a list of the current challenges to help the co-chairs know what to focus on?

Each workgroup will need to begin focusing on exploring:

i. What information is needed and what tools will be used for data gathering?

ii. What are the challenges?

iii. How do we rectify those challenges?

e. Unanimously approved

B. **2024 Timeline of analysis and recommendations** – Presented by M.Brewster

1. Based on the deadline of the final report (Dec 1, 2024) per legislation, there is quite a bit at hand for us as a commission. Deadlines are tight and so we have developed a timeline for the next 11 months.

a. H.Bagnall moved to adopt the timeline based upon the final report deadline of December 1, 2024. M.Rossman seconded the motion.

b. Questions and Discussions:

i. Indiana's GPHC had funding and initial assessment conducted, what funding does our commission currently have? Maryland CoPH didn't kick off until early November; so there were concerns that the Indiana model cannot be replicated within current timeline and with limited resources

c. Instead of pushing back deadline, friendly amendment proposed by G.Branch to approve current timeline but simultaneously ask to extend timeline. Seconded by F.Phillips.

d. A.Kelly and H.Bagnall agreed with proposed amendment and will work with their colleagues to ensure an extension is well received

e. Unanimously approved with friendly amendment

C. Public meeting regions – Presented by M.Brewster

1. Required: 3 public meetings held in different regions in state March through June

a. Western Maryland, Central Maryland, Eastern Shore, Southern Maryland

i. Locations chosen based on LHDs that had ability to do hybrid options and host a certain number of people

ii. Hosted by one LHD

1) Western - Washington County
2) Eastern Shore – Talbot County
3) Central – Howard County
4) Southern – St. Mary's County

b. F.Phillips moved to adopt the specified regions for public meetings. G.Branch seconded the motion.

2. Questions and Discussions:
   a. Concern expressed about representation for central Maryland. Consider PG, Baltimore City, or Montgomery County
3. C.Blake Fall proposed an amended motion that we include a fifth site in central Maryland to be either (dependent upon technical capabilities): Prince George's Co, Baltimore City or Montgomery County. Seconded by M.Spencer
4. Unanimously approved with amendment

IX. Announcements

A. Support from MACHO and CDC Foundation
   1. MACHO entered a collaborative agreement with CDC Foundation to provide staffing support to the local health officers co-chairing commission and co-chairing the 5 workgroups, and to assist with technical expertise

B. Indiana site visit: Feb 22-23, 2024
   1. Co-chairs visiting
      a. Interviews with those who served on commission
      b. Virtual interviews will also be conducted

X. Adjournment

A. Meeting was adjourned at 5:09pm upon motion of C.Blake Fall, which was seconded by F.Phillips

B. Next meeting: February 1, 2024, 2-5PM at Baltimore County Dept of Health with virtual option