



**MARYLAND  
COMMISSION  
ON PUBLIC HEALTH**

**September 05, 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. August 01 Minutes Review and Approval
- VI. Guest Presentation: Chad Perman, MDH Office of Primary Care
- VII. Commission Updates
  - a. Update on LHD Site Visits and Regional Public Listening Sessions
  - b. Final Interim Report framework and timeline
- VIII. Short Recess
- IX. Workgroup Deep Dive - Governance and Organizational Capabilities: Frances Phillips and Dr. Barbara Bookmyer
- X. Commission Discussion and Reflection
- XI. Announcements
  - a. Next meeting: October 03, 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

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**MARYLAND  
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**Thursday, August 01, 2024 | 2:00 – 5:00 PM EDT**  
Prince George's County Government Building (Hybrid)  
1801 McCormick Dr, Upper Marlboro, MD 20774, USA

## **MEETING MINUTES**

**Commissioners present** (in person or virtually)

Christopher Brandt  
Meena Brewster  
Camille Blake Fall  
Nilesh Kalyanaraman  
Oluwatosin Olateju  
Frances Phillips  
Nicole Rochester  
Maura Rossman  
Michelle Spencer  
Allen Twigg

**Commissioners absent**

Del. Heather Bagnall  
Jean Drummond  
Alyssa Lord  
Boris Lushniak

**Commission vacancies**

Urban Local Health Officer  
Senate Representative

**I. Call to Order**

Co-Chair Meena Brewster called the August 2024 meeting of the Maryland Commission on Public Health to order at 2:06pm. Dr. Brewster made opening remarks and thanked everyone for attending. She also acknowledged Prince George's County and Dr. Matthew Levy for their hospitality in hosting the Commission meeting. Co-chair Brewster asked Dr. Egboluche to call the roll. A quorum was established to conduct business.

**II. Adoption of the Agenda**

Dr. Brewster introduced the agenda for review and approval. A motion was made and seconded to adopt the agenda. The agenda was adopted without comment.

**III. July 11, 2024 Minutes Review and Approval**

Co-chair Brewster noted the July 11, 2024 meeting minutes were distributed electronically ahead of today's meeting and copies were available in the back of the room for review. She asked for comment. Commissioner Nicole Rochester noted her name was incorrectly spelled in several places with an *H* and asked for the scrivener's error to be corrected. Commissioner Fran Phillips moved to approve the minutes with amendment, Co-chair Olateju seconded. The minutes were approved without dissent; Dr. Brewster abstained since she was not present at the July meeting.

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**IV. Guest Presentation** by Dr. Georges C. Benjamin, Executive Director of the American Public Health Association

Co-chair Brewster asked Co-Chair Olateju to introduce the guest speaker for the meeting, Dr. Georges C. Benjamin, Executive Director of the American Public Health Association. Dr. Benjamin acknowledged his multiple perspectives over the course of career, having served in clinical settings, local public health settings, in executive leadership at the Maryland Department of Health, and now as an advocate of public health in the nonprofit sector. He offered remarks on the state of public health today and opportunities to improve the system.

Dr. Benjamin noted that the public health system evolved over time and was not strategically created at a particular point in time. Rather, it is a partnership between state, federal, local, and nonprofit entities. While many partners operate in this space and would say they are doing the work of public health, Dr. Benjamin contends that governmental public health is the only entity on the hook and cannot walk away. Nonprofits and associations can help extend the support of public health, serving as capacity extenders and early warning systems.

Despite the myriad of concerns about how to quantify or measure the work, Dr. Benjamin noted that public health is highly scrutinized and has many mechanisms that ensure performance and accountability, such as auditors, accreditation boards, and policymakers who exercise oversight functions. Even so, funding and support seem to follow the crisis curve with temporary increases in funding and lasting increases in performance expectations. This is especially challenging as crises exist in context of other challenges – mental health needs, chronic disease burden, and other barriers that do not disappear despite the changing priority. For example, basic public health issues persisted during the COVID-19 pandemic response.

Lessons learned and research from earlier outbreaks such as HIV/AIDS and SARS helped lead to more effective COVID-19 response, especially therapeutics such as monoclonal antibodies and mRNA vaccines. The public health system has the capacity and charge to continue this type of system innovation and amplification of past lessons learned.

Dr. Benjamin highlighted how technology and social media have changed the practice of public health. Innovations in information dissemination and communication have democratized the field and scientific messaging is now competing with social media that now drives individual health behaviors and decisions. This leads to health policy being overtly political.

Next generation public health system has to be robust and sustainable. The ideal

role for the health officer at any level is to be Chief Health Strategist with an agency structured to deliver the 10 essential services. This means going forward that:

- Data and IT system must be actionable and modern to match current needs
- Harmonize statutory authorities across jurisdictions
- Adequate/sustainable funding
- Vibrant, cross-sector partners
- Accountable accredited systems

Dr. Benjamin remarked that he felt the structure of Maryland's public health system is a national model of what a health and human services mega agency ought to look like as it contains all the essential functional areas to ensure delivery of essential public health services. Even so, there are opportunities for improvement, but overall it is a great setup. Particular features he felt important to ensure were retained or further improved are:

- Every jurisdiction has a local health officer as Chief Health Strategist by law
- Agency structured to deliver 10 essential/foundational services
- Maryland Department of Health data systems are ripe for innovation and interoperability
- Funding could be improved and made more sustainable. The All-payer system in Maryland is a game changer and could lead the way to provide more flexibility in the system.
- Businesses/private sector are under-utilized and under-engaged in partnerships
- Many local health departments and the state health department are accredited by the Public Health Accreditation Board (PHAB)

Specific changes that Dr. Benjamin identified were strengthening core public health infrastructure, incentivizing workforce pipelines into governmental public health, creating state of the art health info & data exchange pathways, linking systems across sectors, and requiring accreditation and accountability across all health entities. Dr. Benjamin then answered questions from the Commission and workgroup members.

**V. Break**

Co-chair Brewster moved the recess up on the agenda in light of the time and noted that Commission updates would occur after the brief recess. The meeting recessed at approximately 3:45pm.

**VI. Commission Updates**

The Commission resumed business at approximately 4:00pm. Co-chair Brewster

asked Mr. Hatchett to provide updates on the Commission's activities. Mr. Hatchett briefly discussed the Commission's overall project timeline, key activities for the remainder of the calendar year, and the upcoming deep dive report outs from the workgroups. He noted in particular that attendance at the deep dive sessions would be instrumental for Commissioners and the value of the dialogue was critical to identifying initial themes for recommendations.

## **VII. Public Health System Assessment Overview**

Dr. Brewster asked Dr. Kleinman to introduce the assessment partners and offer remarks.

Brittany Bugbee discussed how the assessment partners intended to collect and analyze the data for the assessment responses. She noted that more than 200 questions were generated by workgroups. Academic partners categorized them into six themes: organizational structure; funding; communicating health information; technology and data systems; workforce; partner and public engagement. Workforce was a cross-cutting theme in some ways; several workgroups had questions about training and education needs. Challenges, needs, and health equity were identified as cross-cutting themes. Review of the FPH services showed that most services were covered in questions submitted, but not all areas. The assessment will include nearly 100 stakeholder interviews and key informant interviews. Ms. Bugbee gave an overview of potential protocols and ways the partners are working to make sure the data collection is representative and respectful of participants' time. Interviews will be offered by zoom and phone.

Dr. Anita Hawkins talked about the ways in which public perspectives will be included in the assessment. This includes the public listening sessions, online comments, and potentially a public survey.

The Commissioners discussed the proposed protocols and general themes of submitted questions. It was noted that health equity has been identified as a core item of interest and cross-cutting theme, but the questions shown in the presentation did not reflect that. Ms. Bugbee acknowledged it was not representative of the full slate of questions, but that there were multiple questions within each area that touched on equity themes. She indicated they were willing to continue refining those and engaging subject matter experts to ensure the questions reflected the priorities of the Commission.

## **VIII. Announcements**

Co-Chair Brewster then made announcements. She highlighted the upcoming Talbot County Health Department Site Visit and Eastern Shore Listening Session and asked Commissioners and workgroup members to do their best to attend. She noted the next monthly meeting of the Commission will be Thursday, September 5

in the same location at Prince George's County Government Building from 2:00 pm to 5:00 pm. Dr. Boris Lushniak will preside.

**IX. Adjournment**

Seeing that the business had been concluded, Dr. Brewster invited a motion to adjourn. Commissioner Nicole Rochester moved to adjourn the meeting; Commissioner Michelle Spencer seconded. The motion was approved without dissent and the Commission adjourned its monthly meeting at 4:55pm.



**MARYLAND  
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ON PUBLIC HEALTH**

# Welcome

## **September 05, 2024**

*This meeting will be recorded and posted  
on the Commission's public website.*



**MARYLAND  
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# Roll Call

Commissioners: *please say present when your name is called.*

Workgroup members: *please post your name and workgroup in the chat box or on the sign-in sheet.*





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# Adoption of Agenda

*Commissioners: Please signify your voice  
vote by saying "aye" or "nay" when the vote is  
called.*



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# Approval of Aug. 05 Minutes

*Commissioners: Please signify your voice  
vote by saying "aye" or "nay" when the vote is  
called.*



# Maryland Primary Care Program (MDPCP)

Presentation to the Maryland Commission on Public Health

**Chad Perman**  
Executive Director, MDPCP Management Office

September 5, 2024

# Agenda

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- Overview of MDPCP
- Key Areas of Public Health Overlap
- Accomplishments
- What's Next

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# Overview of MDPCP

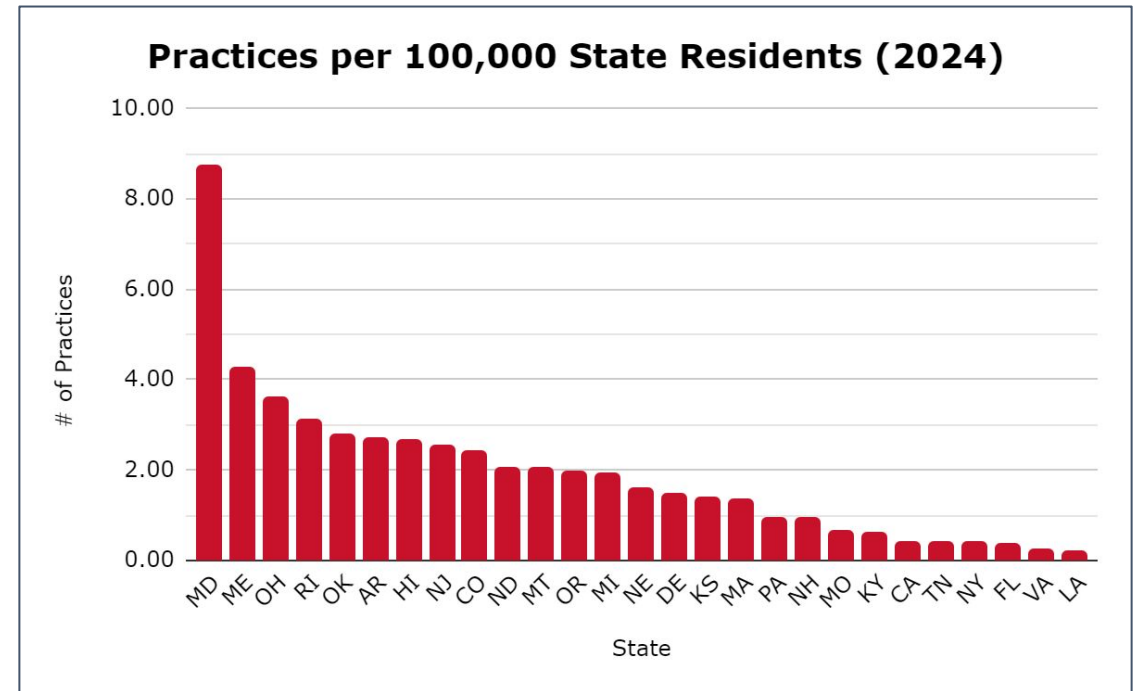
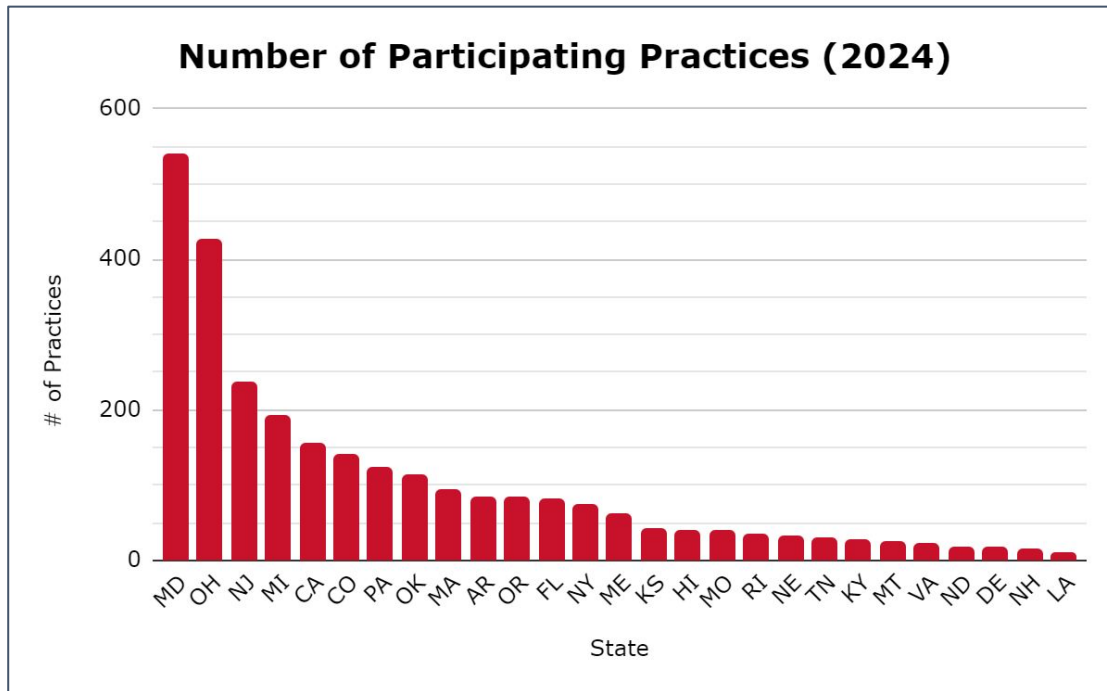
# Key Facts

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- 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.
- Approximately \$200M annually in Federal dollars is sent directly to primary care practices for patient care.
- Foundation to any new Health Care Model agreement with federal government

# Largest Medicare Advanced Primary Care Program in the Nation

When compared to the national Primary Care First model, MDPCP is the nation's largest advanced primary care program by state based on number of practices and practices per 100k residents.

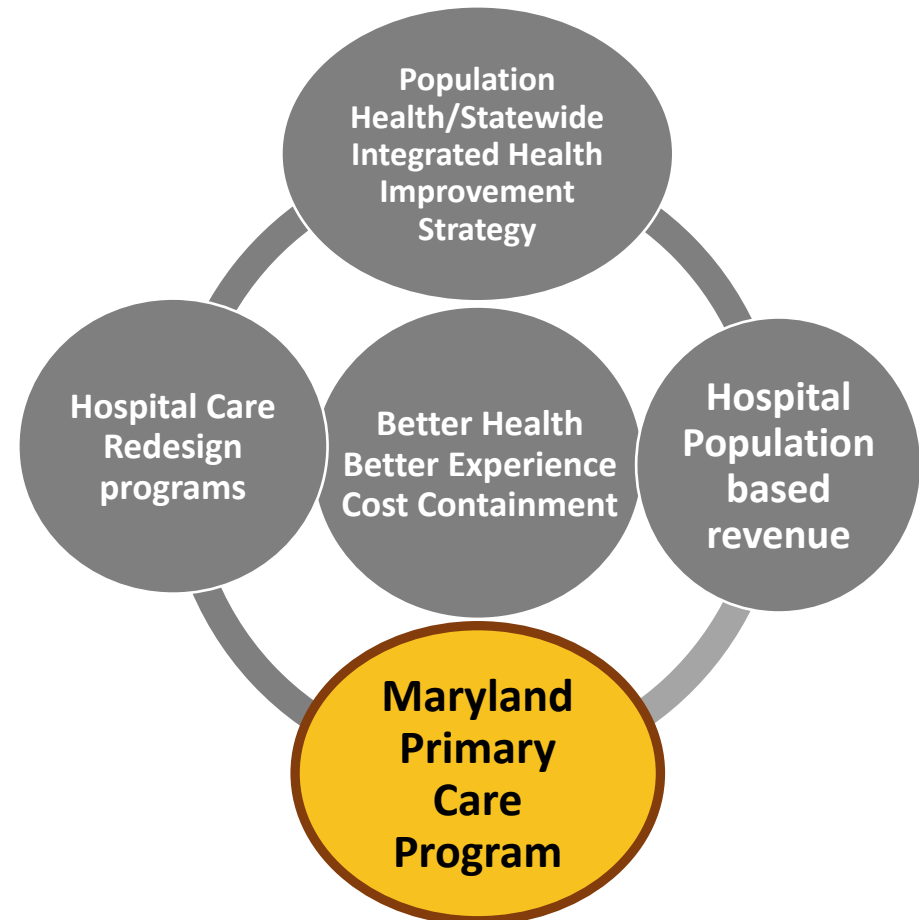


# Maryland Primary Care Program (MDPCP) Supports Statewide Health Transformation

MDPCP is....

- A **statewide advanced primary care program**
- **Goal:** Build a strong, effective primary care delivery system, inclusive of medical, behavioral and social needs
- **Part of Maryland Total Cost of Care model,** a statewide healthcare delivery transformation
- **Reducing avoidable hospital utilization** by improving health and providing the best care at the right time at the right place

## Maryland Total Cost of Care Model

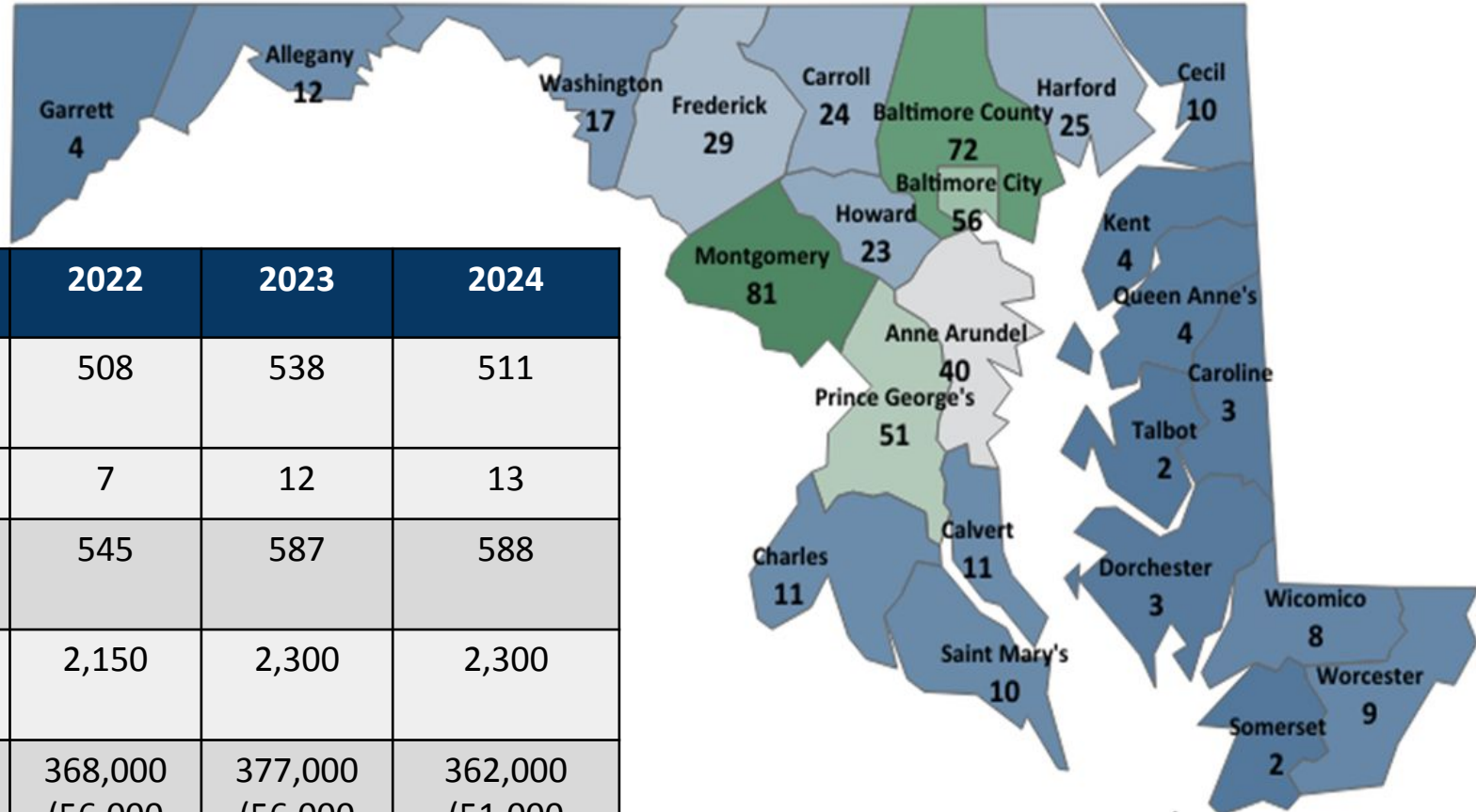




# MDPCP in 2024 - 511 Participating Practices

Support infrastructure – 26 Care Transformation Organizations

Statewide – Practices in every county



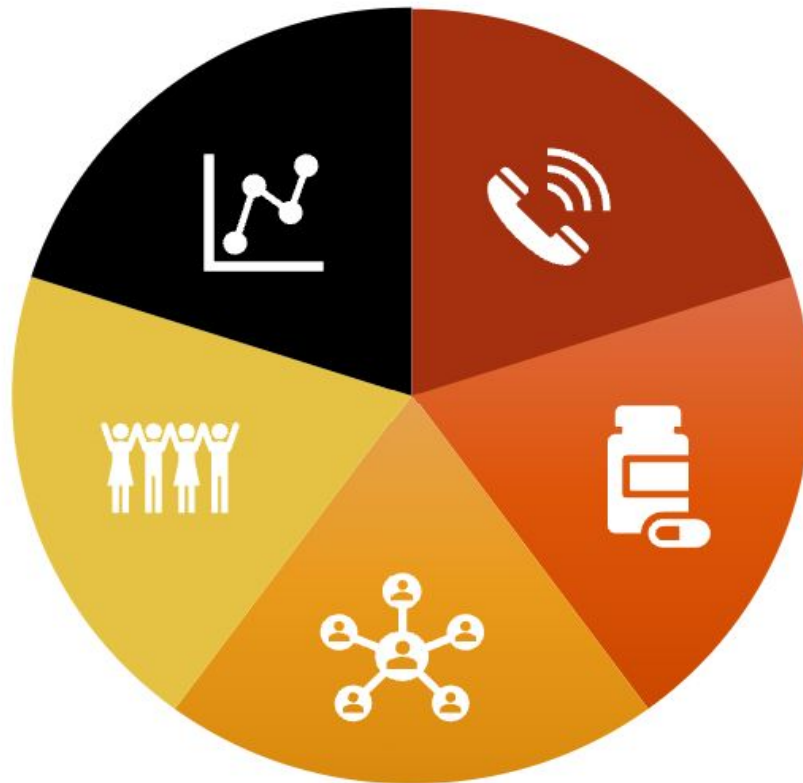
PARTICIPANTS	2019	2020	2021	2022	2023	2024
Practices	380	476	525	508	538	511
FQHCs	-	-	7	7	12	13
Total sites	380	476	562	545	587	588
Providers*	1,500	2,000	2,150	2,150	2,300	2,300
Medicare Beneficiaries attributed*	215,000 (30,000 duals)	326,000 (48,000 duals)	387,000 (58,000 duals)	368,000 (56,000 duals)	377,000 (56,000 duals)	362,000 (51,000 duals)

Largest state program in the nation through 2023 - by number of practices and practices per capita (compared to CMS' national Primary Care First Model)

\*Yearly totals for these metrics are approximate and based on Q1 attribution for the corresponding year.

# Implementing MDPCP's Advanced Primary Care Requirements

## Care Transformation Requirements



**Access & Continuity** – Expanded Access | Alternative Visits (+Telemedicine)

**Care Management** - Risk-Stratification | Transitional Care Management | Longitudinal, Relationship-Based | Comprehensive Medication Management

**Comprehensiveness & Coordination** - Behavioral Health Integration | Social Needs Screening & Referral

**Beneficiary & Caregiver Experience** - Patient Family Advisory Councils | Advance Care Planning

**Planned Care for Health Outcomes** - Continuous Quality Improvement | Advanced Health Information Technology | CRISP

# Overview of Tracks

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TRACK 2

## Advanced

Track 1 requirements + addition of offering of alternative care (e.g., telehealth) social needs screening and linkages, comprehensive medication management, and advance care planning

TRACK 3\*

## Advanced with Upside & Downside Risk

Track 2 requirements + collection of demographics data, prioritizing health related social needs, & expanded alternative care requirements

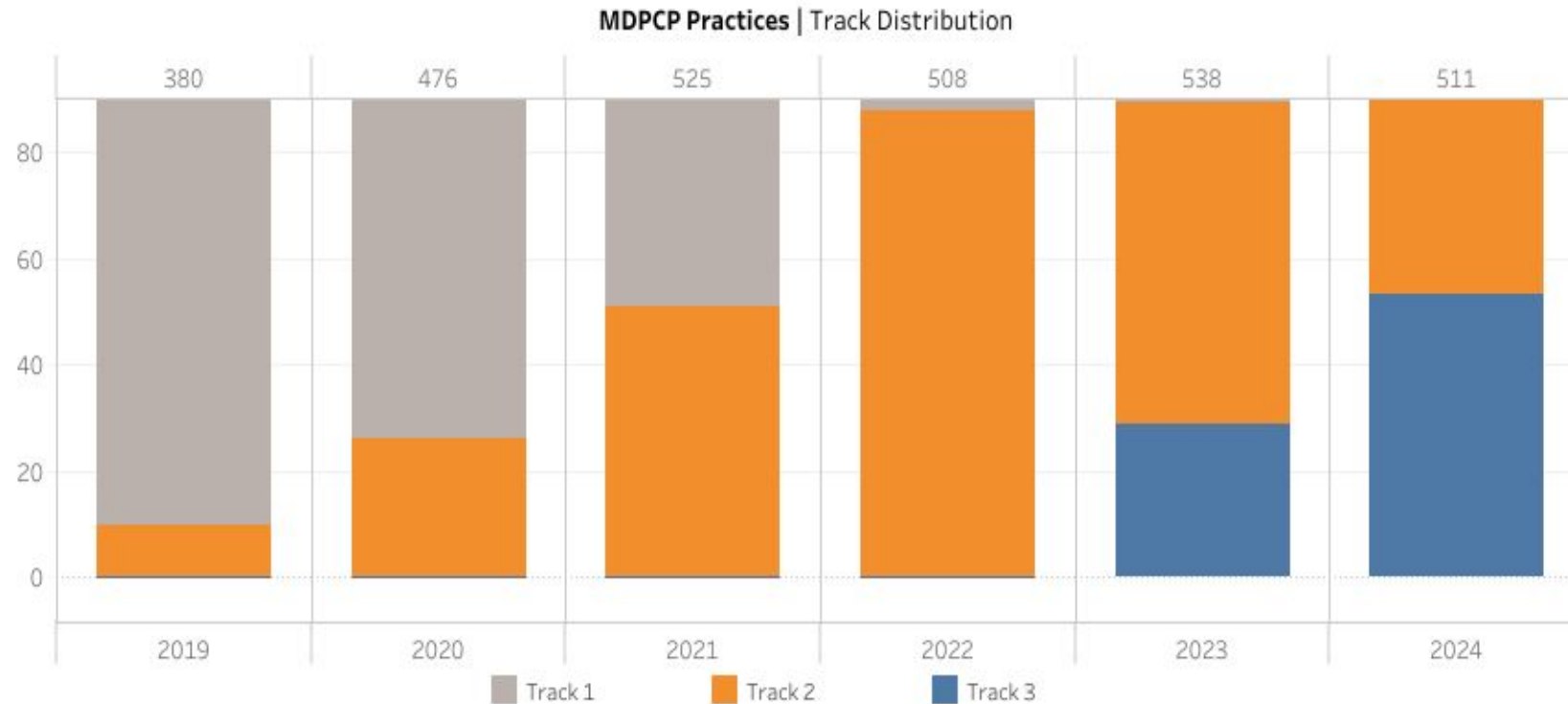
## Payments

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- Care Management Fee (CMF)
  - Performance-Based Incentive Payment (PBIP)
  - CPCP + standard FFS billing
  - Health Equity Advancement Resource and Transformation (HEART) (if applicable)
- 
- Population Based Payment (subject to PBA)
  - Flat visit fee (subject to PBA)
  - Performance-Based Adjustment (PBA)
  - HEART (if applicable)

\*New starters must transition to Track 3 before the start of 2026.

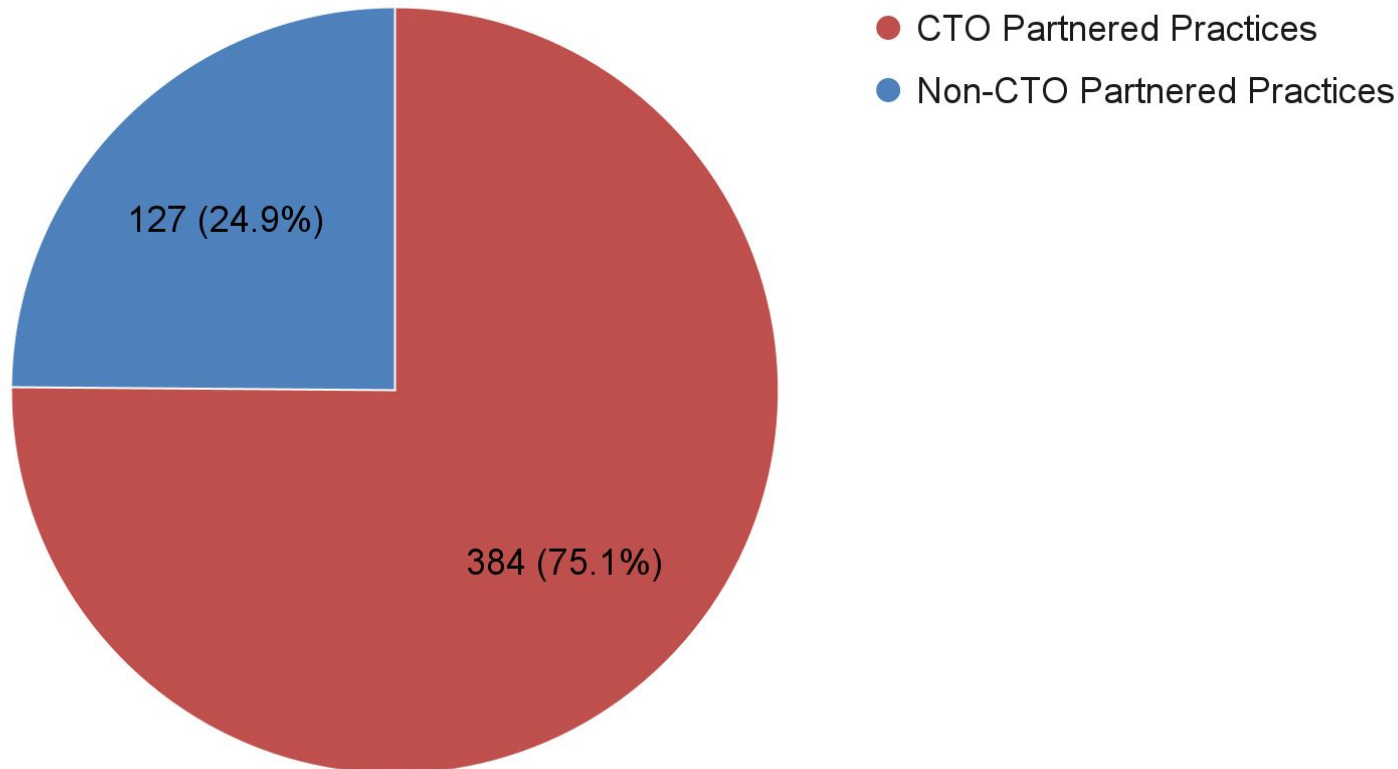
# Practices by Track



# CTO Partnerships

*CTOs are practice support organizations that assist practices with meeting the advanced primary care requirements including care management, data insights and behavioral and social needs*

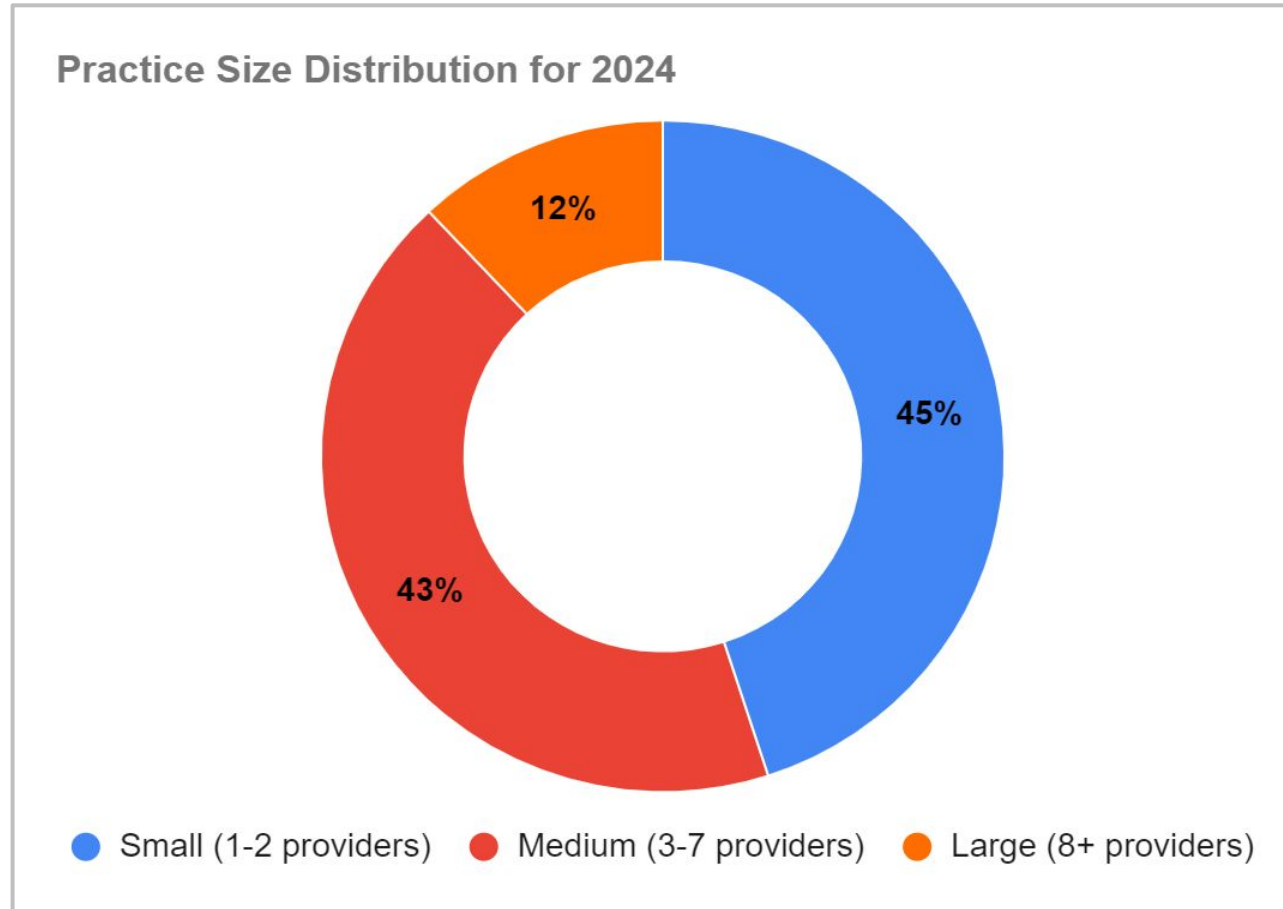
2024 CTO vs. Non-CTO MDPCP Practices



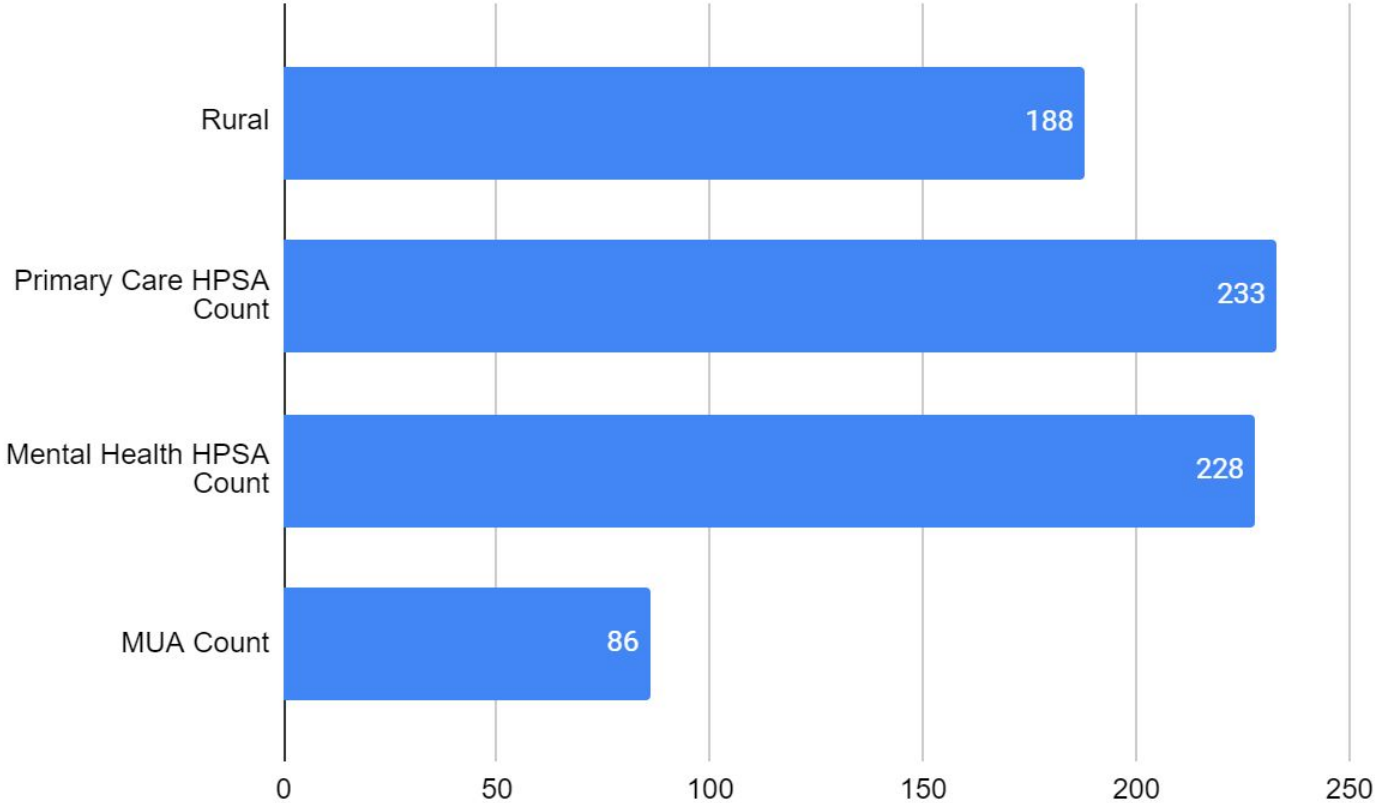
- ~75% of practices have partnered with CTOs in recent years
- ~250k Medicare beneficiaries are attributed to CTOs (69% of MDPCP beneficiaries)

# 2024 Practice Size

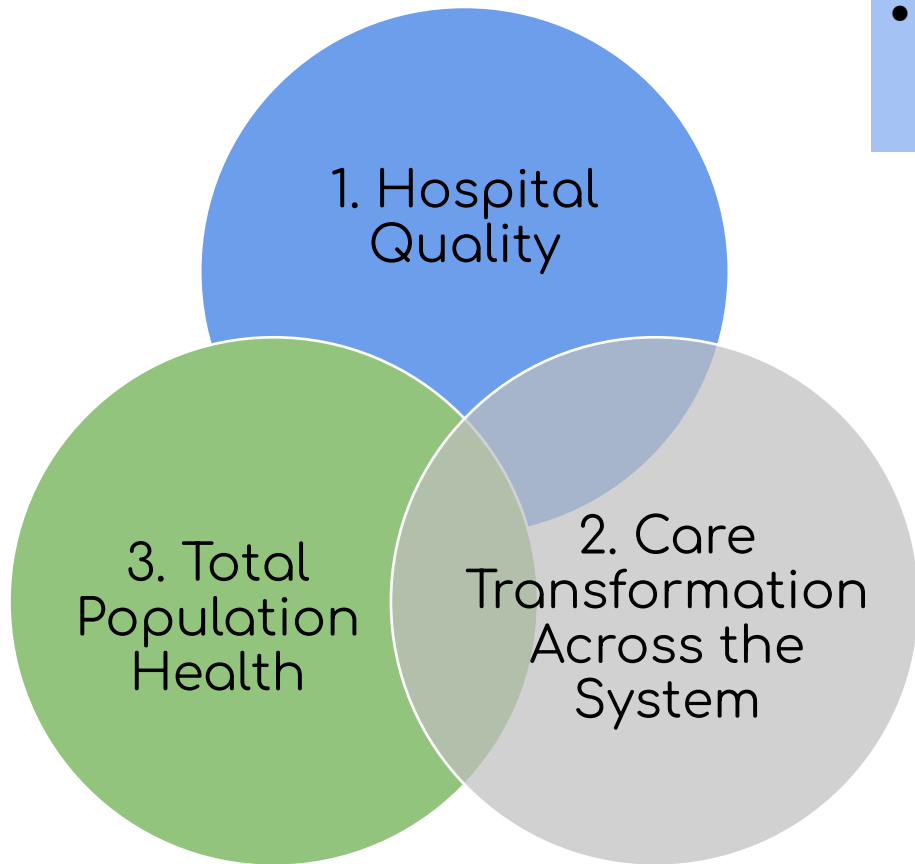
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# 2024 MDPCP Practice Distribution by Underserved Category



# MDPCP Aligned with State's Population Health Strategy (SIHIS)



## Hospital Quality

- **Reduce avoidable admissions**
  - MDPCP focuses on reducing PQIs by building care management infrastructure and providing CRISP/Hilltop data reports

## Care Transformation Goals

- **Improve care coordination for patients with chronic conditions**
  - MDPCP requires 1) timely follow up for Inpatient admissions and ED visits; 2) longitudinal care management

## Total Population Health Goals

- **Priority Area 1 (Diabetes): Reduce mean BMI**
  - MDPCP practice performance on Diabetes A1C quality measures has improved since 2019
  - BMI and follow up plan quality measure
  - Building tools to alert practices on prediabetes and education/QI to refer to DPP
- **Priority Area 2 (Opioids): Improve overdose mortality**
  - 2019 - present - implemented SBIRT into over 339 practices
  - 2024 - begun MOUD implementation
  - 2024 - non-fatal overdose alert for practices



# MDPCP Payer Alignment

Alignment in 5 areas:

1. Financial Incentives/  
Non-visit based payments
2. Care Management
3. Quality Measures
4. Data Sharing
5. Practice Learning

2019

Medicare



2020



2025\*

**Medicaid**  
**(\*IN DEVELOPMENT)**

# MDH Program Management Office

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Program Administration,  
Technical Assistance and  
Infrastructure



- Health Equity
- Public Health Integration
- Analysis
- Behavioral Health Integration

# MDPCP Impacts on Utilization and Costs

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

\*Rates are risk-adjusted, which accounts for differences in patient population illness acuity, to allow for direct comparison

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# Key Areas of Public Health Overlap

# Key Tools for Public Health Infrastructure - Respiratory Disease Response for PCPs



Guides, resources, and templates



Biweekly emails with updates and information



Direct technical assistance from staff



Lab expansion project with BioMerieux

## Strategies Built with the Triple Play Strategy framework

*Triple Play Strategy: Vaccines, Testing, and Therapeutics*

### Primary Care Public Health Update: 8/30 Updates

Good afternoon Maryland Primary Care Providers and partners,

# Program Impacts: COVID-19 Spotlight

- **Higher COVID-19 vaccination rates** in all study months (Dec 2020 - March 2022)
- **12.4%** higher rate of COVID-19 vaccine boosters
- **7.6%** lower rate of overall COVID-19 cases
- **12%** lower inpatient admission rate attributed to COVID-19
- **27%** lower death rate attributed to COVID-19

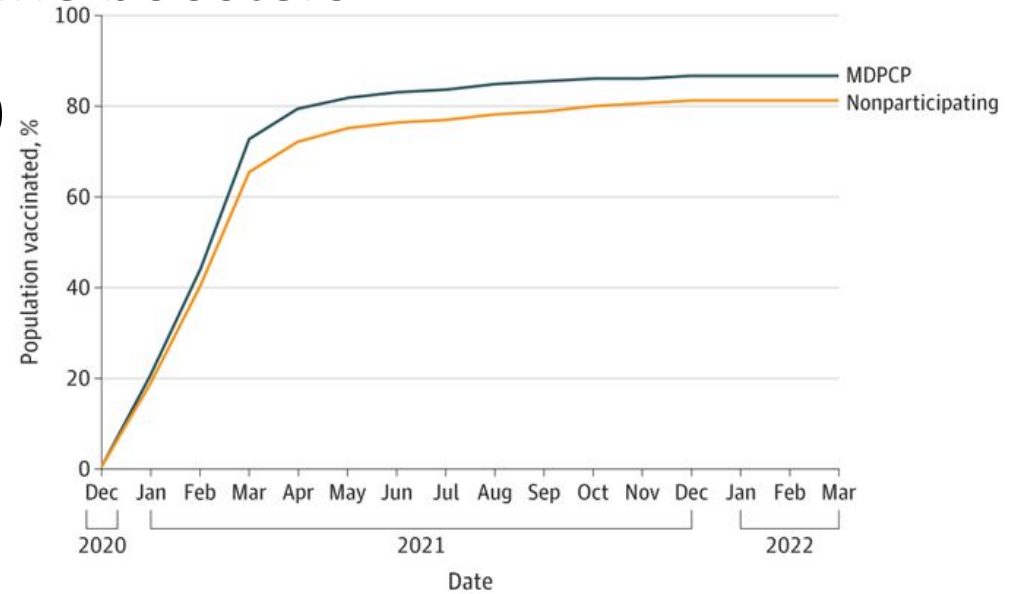


Figure. Vaccination Rates Over Time for Maryland Primary Care Program (MDPCP) and Nonparticipating Practice Groups

# Health Equity Supports

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MDPCP is committed to achieving **equitable quality of care, access to care, and outcomes at the primary care level**. Four core priority areas around health equity are: data, social needs screening and referral, payment, and QI to reduce disparities.

## Data

Enable all MDPCP practices and CTOs to have the foundational data capacity to understand disparities in clinical quality, utilization, and cost

## Social Needs Screening and Referral

Ensure all MDPCP practices and CTOs effectively screen patients for social needs and refer patients to community resources to address those needs

## Payment

Give practices the financial resources to address social needs, specifically the HEART Payment, which directs funding to target beneficiaries' social needs

## Quality Improvement to Reduce Disparities

Build QI capabilities and infrastructure within practices to reduce disparities in measures such as PQI-like events, ED events, and hospital follow up rates

# HEART Payment Enables Practices to Directly Address Unmet Social Needs

What is the HEART payment?

Additional \$110 PMPM for attributed MDPCP beneficiaries who have:

High  
Medical  
Complexity  
(HCC)

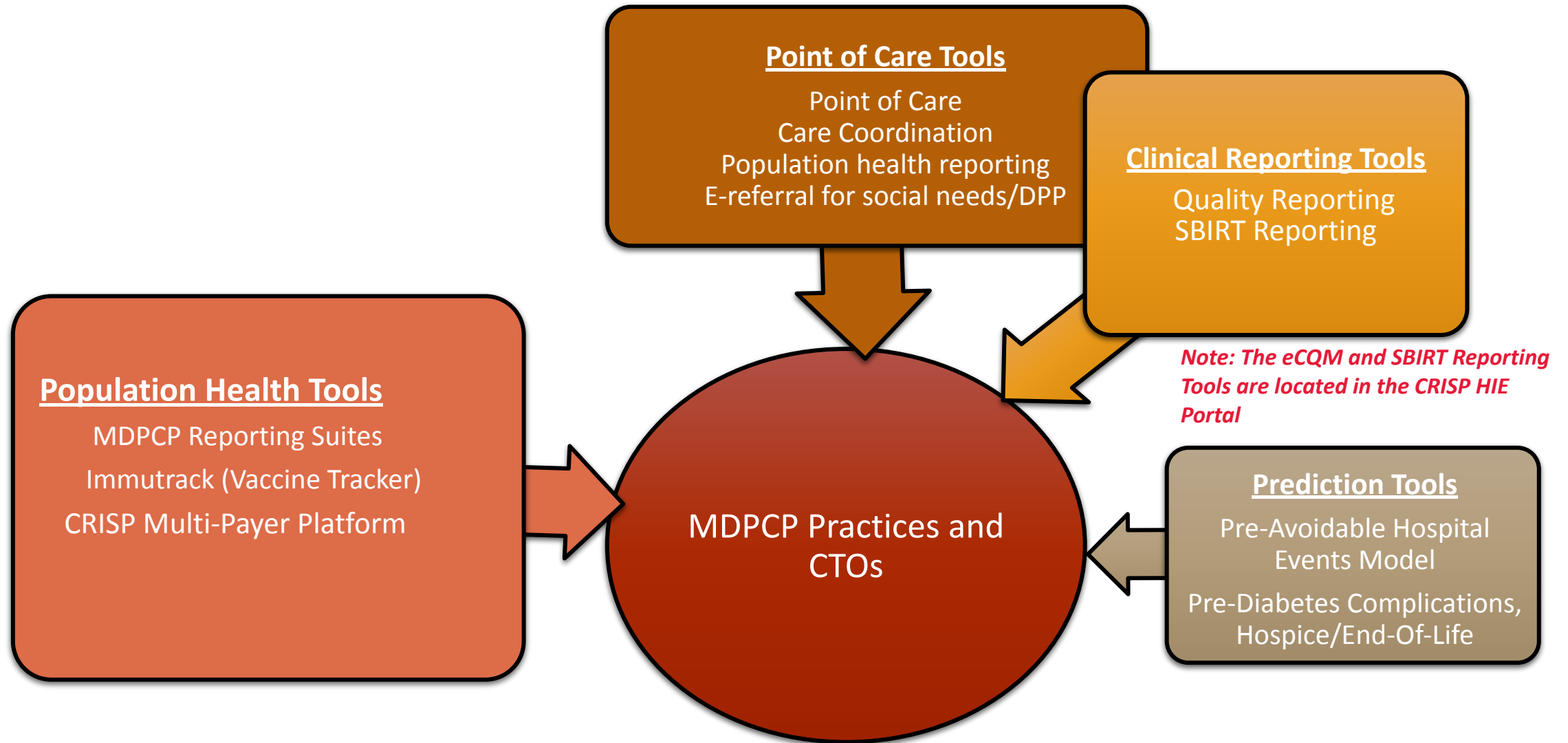
High Area  
Deprivation  
Index (ADI)

HEART has allowed practices to accomplish:

- Partnership with a local farm co-op to deliver packages with fresh produce for beneficiaries with food insecurity
- 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
- No-cost visits with dietitians, nutritionists, and diabetes educators for support with diet and chronic disease management



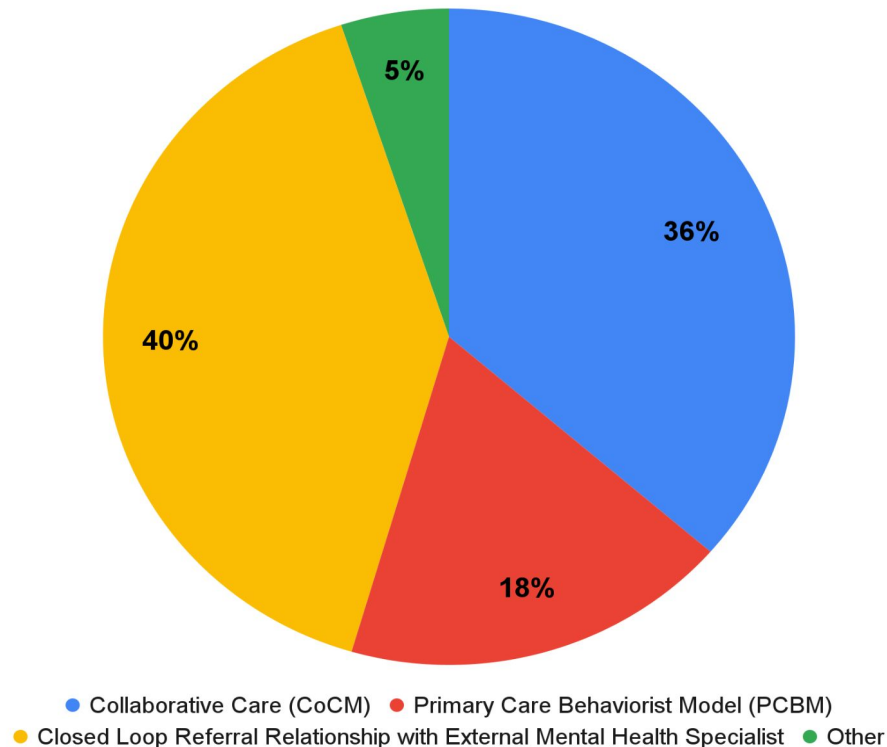
# Population Health Data for Primary Care



# Behavioral Health Integration in MDPCP

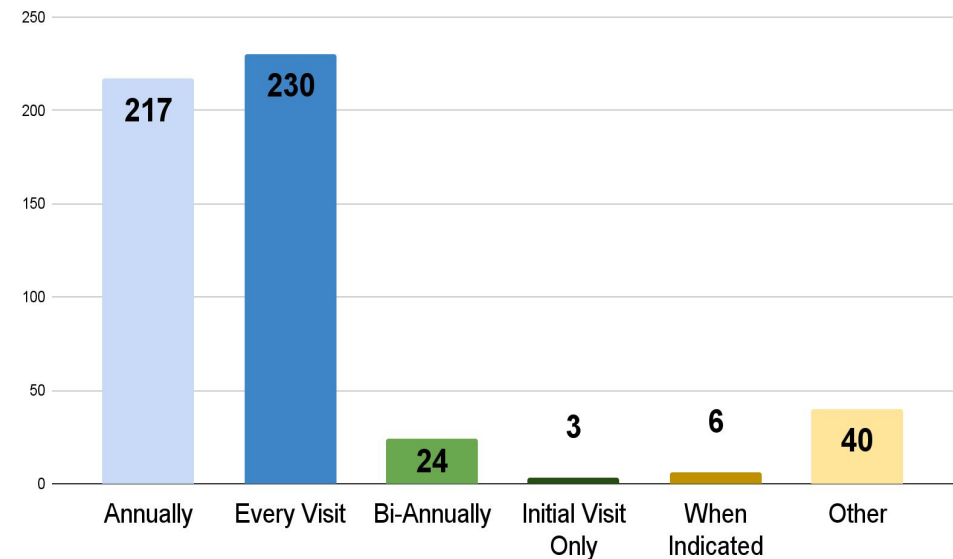
**Various models for integrating mental health services into primary care - 2023**

Care Model to Address Mental Health Needs



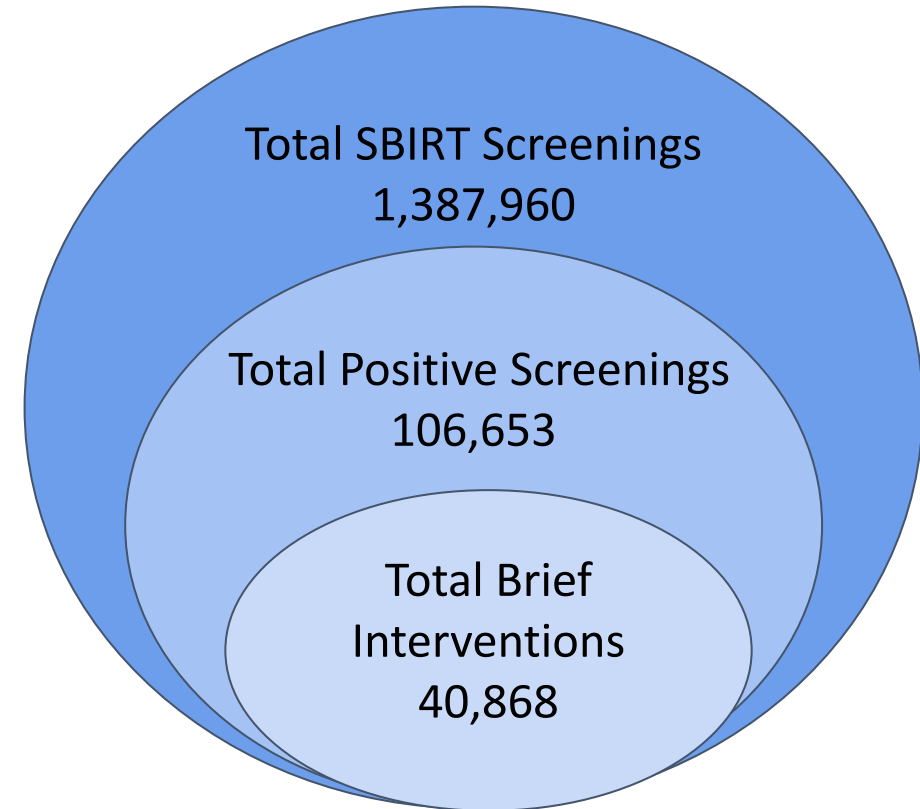
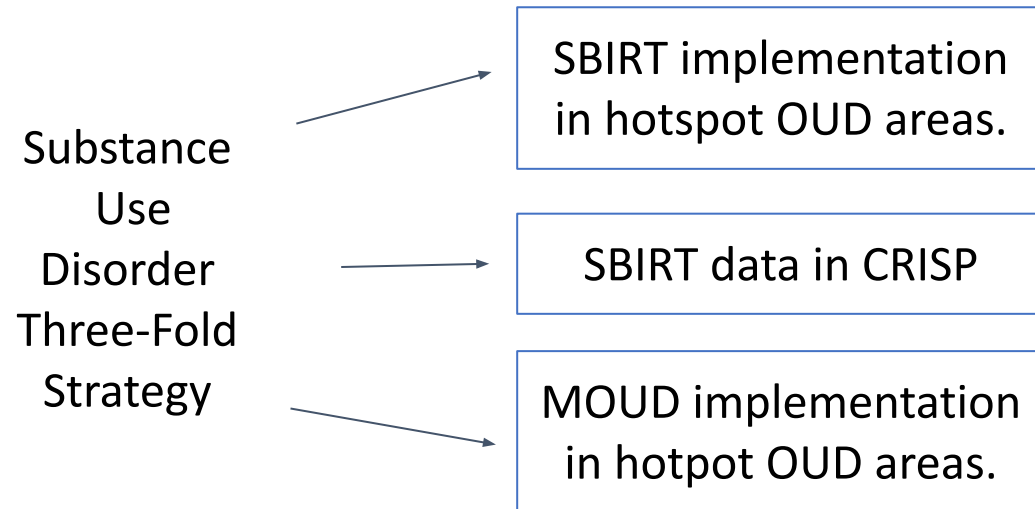
**100% of practices report routinely screening patients for mental health needs in 2023**

Screening Frequency



# Behavioral Health Integration in MDPCP

**Overall: 64% of practices have implemented SBIRT through State technical assistance**



Data reported  
Aug '21 - June '24

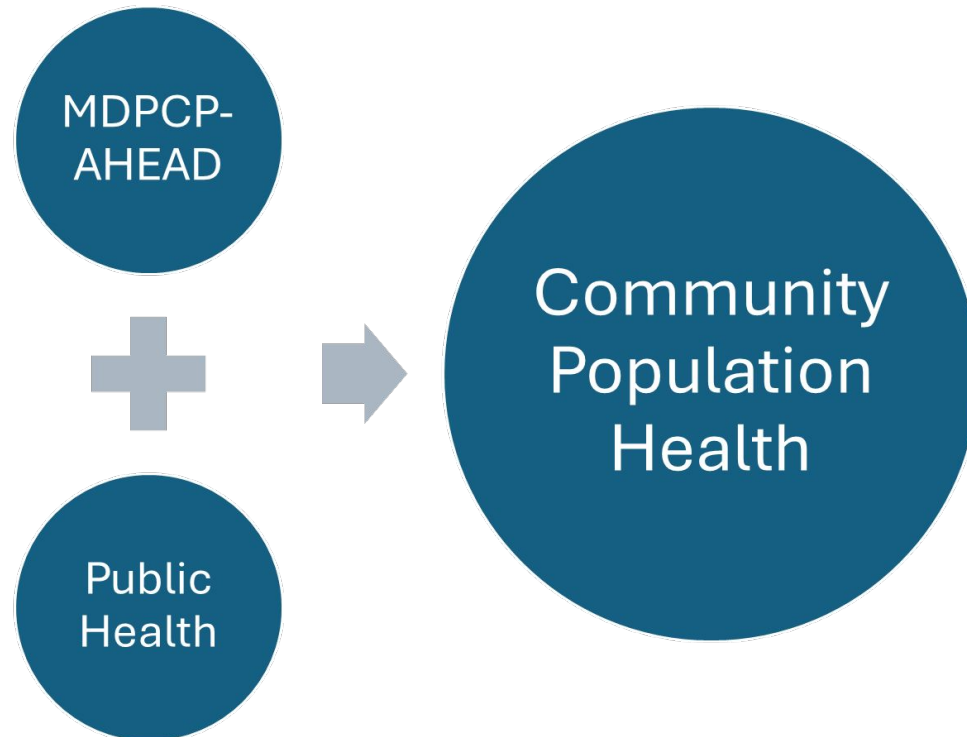


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# What's Next

# Future State - Advancing Primary Care and Public Health Integration

- **MDPCP transitions to AHEAD Model** - broadened advanced primary care approach to Medicare and Medicaid
- **Public Health entities actively partner with primary care practices** around state to address physical, behavioral and social needs



# Thank You!

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Check out the [MDPCP website](#) for updates and more information



Email [mdh.pcmode@maryland.gov](mailto:mdh.pcmode@maryland.gov) with any questions or concerns

## Any questions?



**MARYLAND  
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# Commission Updates

*Shane Hatchett*



# Timeline

2024

2025



	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Meeting Date, Chair	05 Sep, Boris	03 Oct, Tosin	07 Nov, Meena	05 Dec, Tosin	23 Jan, Boris	20 Feb, Meena
Focus	Deep dive into Gov. / Org Capabilities	Deep dive into Comms/PE	Deep dive into Funding; adopt interim report	Submission of interim report; review progress	Deep dive into Data & IT	Deep dive into Workforce
Assessment	<ul style="list-style-type: none"> <li>Assessment activities underway, outreach begins</li> </ul>	<ul style="list-style-type: none"> <li>Assessment activities underway/released; guides developed</li> </ul>	<ul style="list-style-type: none"> <li>Assessment shift to KII/focus groups</li> <li>Review preliminary trends</li> </ul>	<ul style="list-style-type: none"> <li>KII/focus groups continue</li> <li>Review and analysis</li> </ul>	<ul style="list-style-type: none"> <li>Surveys and assessments completed</li> <li>Analysis underway (except PH WINS)</li> </ul>	<ul style="list-style-type: none"> <li>All findings and analysis complete (except PH WINS)</li> </ul>
System Engagement	<ul style="list-style-type: none"> <li>Chad Perman, MDH</li> </ul>	<ul style="list-style-type: none"> <li>TBD: workforce panel</li> <li>28/Oct: Baltimore City Site Visit</li> <li>Focus groups/KII meetings begin</li> </ul>	<ul style="list-style-type: none"> <li>TBD: DBM Secretary/Designee</li> <li>Summarize site visit findings</li> <li>Focus groups/KII meetings continue</li> </ul>	<ul style="list-style-type: none"> <li>Focus groups/KII meetings continue with system partners</li> <li>Submit final interim report (1 Dec)</li> </ul>	<ul style="list-style-type: none"> <li>TBD</li> </ul>	<ul style="list-style-type: none"> <li>TBD</li> </ul>
Public Engagement	<ul style="list-style-type: none"> <li>Public comment form and phone line still open</li> </ul>	<ul style="list-style-type: none"> <li>28/Oct: Baltimore City Listening Session</li> <li>Public comment form and phone line close</li> </ul>	<ul style="list-style-type: none"> <li>Summarize public comments</li> </ul>	<ul style="list-style-type: none"> <li>Issue press release and social media campaign highlighting CoPH work</li> </ul>	<ul style="list-style-type: none"> <li>TBD</li> </ul>	<ul style="list-style-type: none"> <li>TBD</li> </ul>





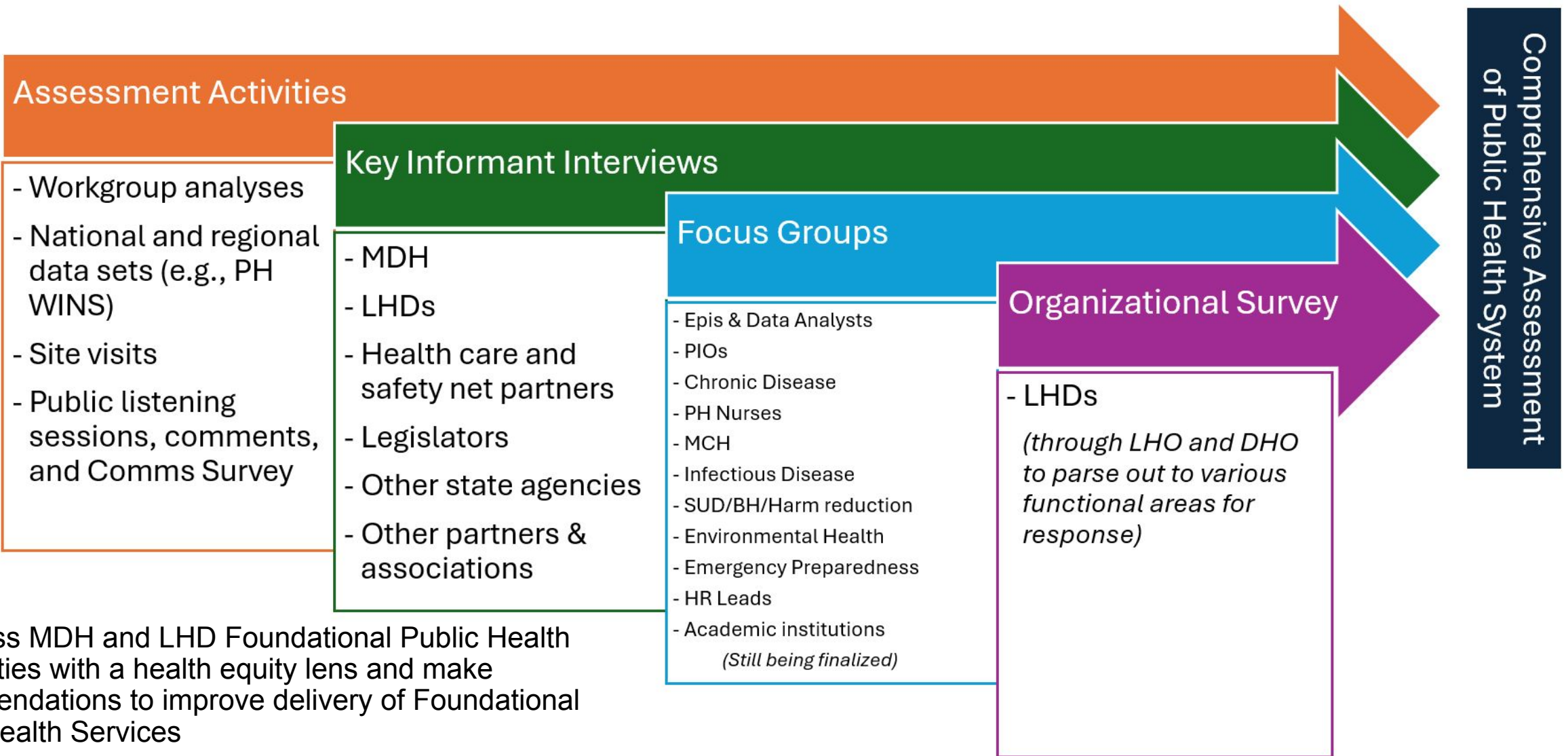
# 2025 Meeting Dates

- January 23
- February 20
- March 13
- April 03
- May 01
- June 05
- July 10

**Note:** No planned changes for venue or hybrid options at this time.



# Updated Assessment Framework



To assess MDH and LHD Foundational Public Health Capabilities with a health equity lens and make recommendations to improve delivery of Foundational Public Health Services



# Assessment Update

- Regularly meeting with Assessment Team (biweekly) to coordinate
- Continuing to refine questions and respond to feedback from Commissioners and workgroups
- Managing scope vs. timeline
  - Fidelity to the statute and goals
  - Focus areas of Commission
  - Feasibility



# Final Interim Report

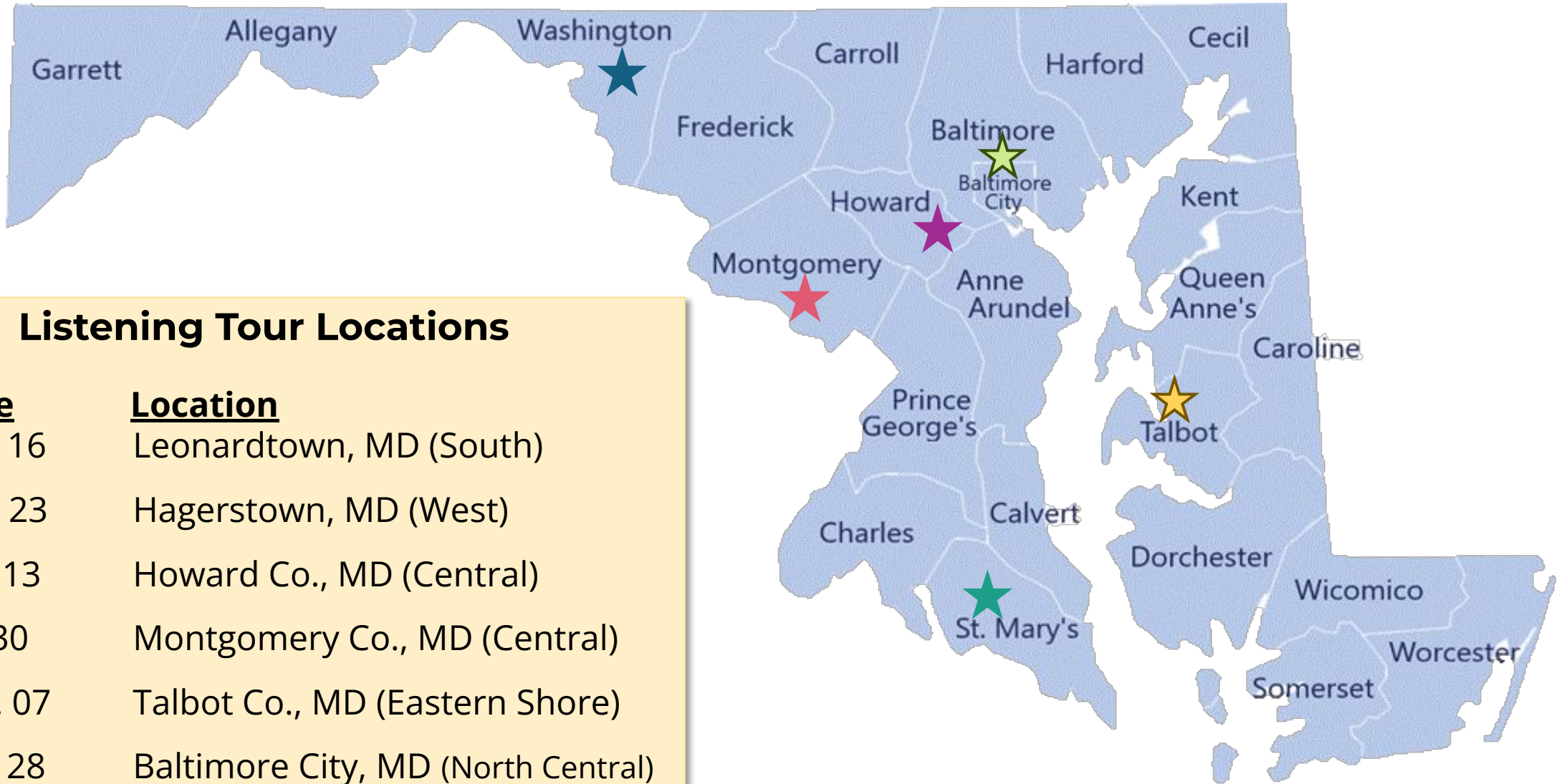
- Template and instructions under development
- Current timeline:
  - Oct. 21 - Workgroup report drafts due to Coordinators/Staff
  - Nov. 7 - Discuss and adopt report; staff will make modifications based on feedback *(or see note below)*
  - Dec. 1 - Submit Final Interim Report on or before this date

## **Decision point**







Do we schedule another meeting (virtual) in November to continue discussion of FIR?



# Listening sessions



## Listening Tour Locations

<u>Date</u>	<u>Location</u>
 Apr. 16	Leonardtown, MD (South)
 May 23	Hagerstown, MD (West)
 Jun. 13	Howard Co., MD (Central)
 Jul. 30	Montgomery Co., MD (Central)
 Aug. 07	Talbot Co., MD (Eastern Shore)
 Oct. 28	Baltimore City, MD (North Central)

Current as of 30 August 2024. Check website for updates.



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# Break

**September 05, 2024**

*The Commission has temporarily recessed  
and will reconvene soon. Recording will  
continue.*



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# Deep Dive: Governance & Organizational Capabilities

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





# Focus:

## The governance and organizational capabilities of Maryland's governmental public health system

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





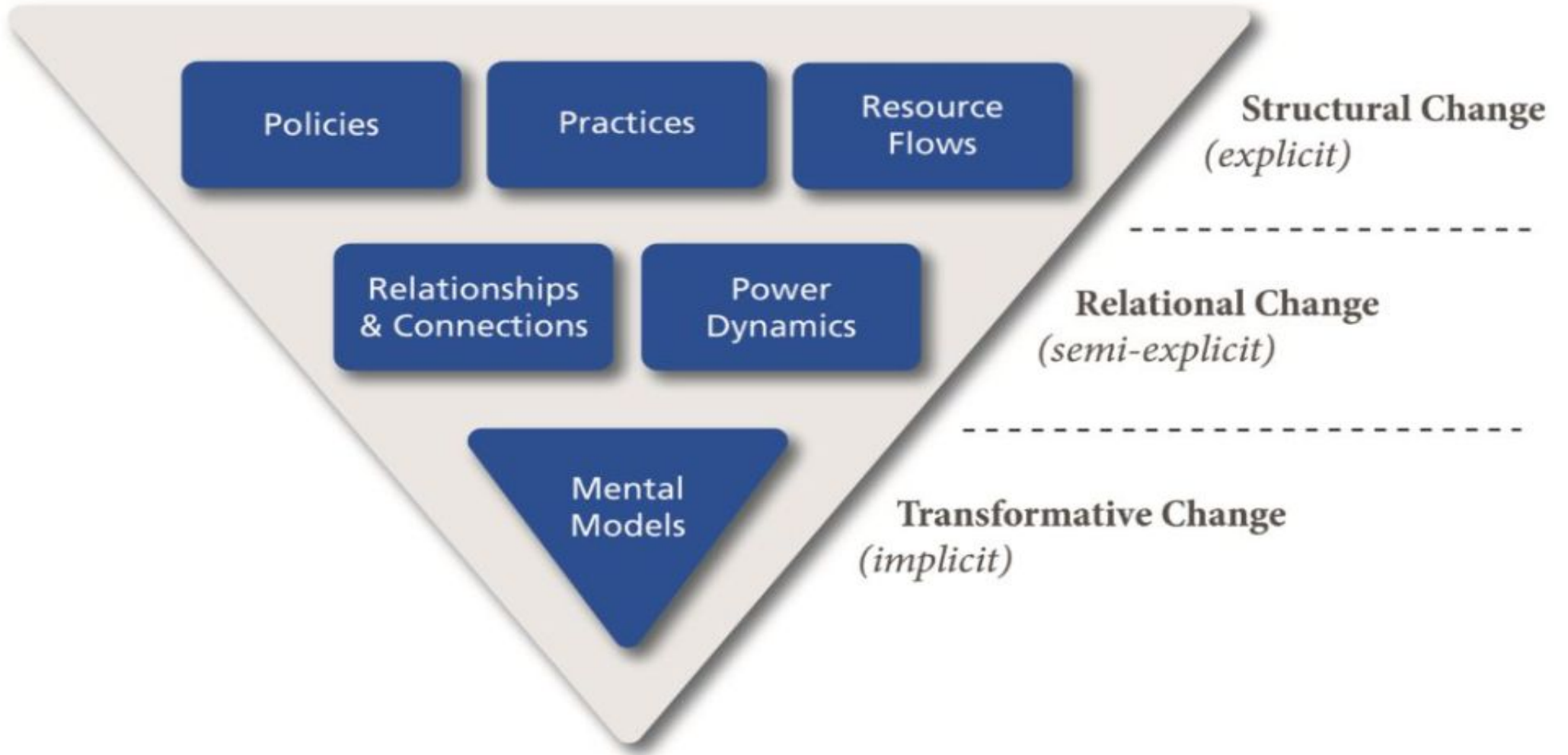
## Foundational Areas



## Foundational Capabilities



## Six Conditions of Systems Change





# Membership

- Barbara Brookmyer, MD, MPH
  - Fran Phillips, RN, MHA
  - Meena Brewster, MD, MPH
  - Angela Cochran, MS
  - Erica Drohan, CFA
  - Marie Flake, MPH
  - Joan Gelrud, MSN, CPHQ
  - Isis Gomes, MPA
  - Kathleen Hoke, JD
  - Nilesh Kalyanaraman, MD
  - Maria Maguire, MD, MPP
  - Matthew McConaughey, MPH
  - Maura Rossman, MD
  - Julie Cady-Reh, MS, MBA *(until 3/24)*
  - Michelle Spencer, MS
  - Wendy Wolff, MPH
- Support Staff:
- Sarah Kolk, MPH *(until 7/24)*
  - Hawi Bekele Bengessa, BA
  - Shane Hatchett, MS



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# Work to Date



# Activities

- 9 meetings (1/8, 2/5, 2/26, 3/25, 4/22, 6/4, 6/24, 7/22, 8/26)
- Attendance at Commission meetings, site visits and listening sessions
- Outreach to other state agencies to speak to workgroup or inform the process



# Experts Consulted

- Jon Kromm, HSCRC Executive Director
- Mary Bearden, Sr. Counsel at Office of the Attorney General
- Indiana Department of Health staff
- Speakers at Commission meetings
- Participants at Site Visits and Listening Sessions



# Resources Examined

- Network for Public Health Law
- Public Health Accreditation Board
- National Academy for State Health Policy
- Bipartisan Policy Center
- Centers for Disease Control and Prevention (CDC)
- Peer states: Washington, Colorado, Tennessee, Indiana
- Peer reviewed literature



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# Health Equity and Cross-cutting Themes





# Topic of Inquiry #1: Health Equity

- Do Maryland's public health leaders have sufficient ongoing education, organizational support and accountability expectations to detect and act on prevailing cultural biases?
- 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?
- Is health equity enhanced in those states, unlike Maryland, which have a State board of health?
- How is the role of the Commission on Health Equity evolving related to governance and organizational capabilities?



# Topic #1: Health Equity *(cont'd)*

- Can and do PH agencies act to advance equity when Federal eligibility requirements categorically exclude some populations, placing a greater burden on such communities?
- How frequently do PH agencies and partners engage in a systematic examination of health equity in all policies?
- Are there governance or administrative barriers to cross-jurisdictional data sharing and collaborative interventions, particularly in the Baltimore metro area?



# Cross-cutting Themes

To be further explored - how prevailing governance structures and practices impact specific areas such as:

- Infant and maternal mortality
- Preparedness
- Overdoses
- COVID-19



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# Initial Topics of Inquiry



# Topic #2: Leadership Training and Professional Development

- Is ongoing high quality leadership training available for senior PH officials?
- Can the orientation and onboarding of newly appointed PH leaders be improved?
- Are there established opportunities and resources for cross-jurisdictional exchange of evidence-based or promising practices?
- What role does Leadership Development and Professional Development play in personnel (organizational) stability and organizational competence at the state and local level?



# Topic #3: Legal Considerations on Shared Governance

- 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)?
- 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?
- 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)?
- Should amendments to State statute be considered to strengthen or modify emergency enforcement measures authorized under the Public Safety Act?



# Topic #4: Policy Development and Implementation

- Are state and local PH leaders given opportunities to effectively and appropriately contribute to State policy development and implementation?
- Are state and local PH leaders represented in the shaping and implementation of State environmental policy?
- Do local PH leaders provide input to Medicaid and Behavioral Health Administration on policy matters directly impacting local public health?
- 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 ?



# Topic #5: Accountability and Performance Management

- Are current performance management systems for senior PH officials based on explicit and appropriate goals and metrics?
- Are the goals and performance measures for state and local PH leaders and agencies synched with State health improvement goals?
- Are local boards of health trained and supported in discharging their oversight responsibility to assess local PH leadership and agency performance?
- 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?
- How might public health accreditation be used as a tool to address accountability and performance management?





# Topic #6: Local Boards of Health

- Are the minimal State requirements for local boards of health sufficient to provide effective governance to LHDs?
- 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?
- 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.



# Topic #7: Academic Partners

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



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# Continued Exploration



# Remaining Questions

- Are there possible changes to PH governance that could facilitate more effective partnerships:
  - Between LHDs and MDE as previously noted?
  - Between LHDs and MDH's Behavioral Health Administration including clarifying the authority and responsibility of 'local behavioral health authorities.'
- What responsibility and authority do LHDs possess with regard to quality concerns within acute or institutional care facilities?
- 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?



# Input Requested

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



# Focus Next 3-6 Months

- Continue monthly meetings with invited speakers and...
  - Adapt our work to input received from other Workgroups and actively comment on Deep Dives presented by other Workgroups
  - 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)
  - Closely review findings of the assessments for direction regarding governance issues



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# Questions?



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# Adjourned

**September 05, 2024**

*The next Commission meeting is October 03.*