Maryland Commission on Public Health

2024 Interim Report

DECEMBER 2024

MARYLAND
COMMISSION
ON PUBLIC HEALTH

Contents

the Commission

The Maryland Commission on Public Health (the Commission) was established by Governor Wes Moore following the COVID-19 pandemic and other public health crises. The Commission was charged with assessing the impact of the foundational public health capabilities, the public health infrastructure, of state and local health departments and issuing a final report with recommendations to improve public health services.

This interim report summarizes the activities of the Commission in 2024 and provides insight into the next steps in 2025.

Preface to the Report

Special Comments and Recommendations Regarding Maryland's AHEAD Model

An unprecedented opportunity to advance the health of Marylanders emerged just prior to the deadline for this Interim Report. Given the importance of this opportunity, the Commission has decided to begin its 2024 Interim Report with the below special comment and recommendation regarding Maryland's AHEAD Model.

On November 14, 2024, Maryland Health Services Cost Review Commission (HSCRC) staff published a proposed Recommendation to Fund Preparation for Implementation of the AHEAD Model (link). The staff's recommendation on AHEAD implementation will come before the HSCRC on December 11, 2024.

The proposal will require HSCRC approval and legislative action to move forward. Submission of the Maryland Commission on Public Health (the Commission) Interim Report, occurring midway between the release of the proposed AHEAD implementation recommendations and HSCRC's hearing on the matter, prompted the Commission to attach this Special Comment to the Interim Report.

The Commission regards the HSCRC proposal as an extraordinary step. The proposal aims to leverage the State's public and private resources to successfully achieve the AHEAD targets, to align with existing public health efforts and capacity, and most importantly, the proposal promises to measurably improve the health of all Marylanders.

The Commission supports the HSCRC staff recommendation for the reasons noted below and encourages its adoption and full implementation. The Commission also recommends as described below that the HSCRC AHEAD implementation reflects, supports, and leverages the public health capabilities of health departments across the state.

1. Aligned action. HSCRC's AHEAD implementation recommendations will synchronize and accelerate multipronged action on the goals of the just-released State Health Improvement Plan and the forthcoming Health Equity Plan. The State Health Improvement Plan reflects some of the common health priorities of local health improvement plans for each Maryland jurisdiction.

2. Curing disease is not enough to achieve health equity. The AHEAD implementation recommendations establish that hospitals alone cannot attain Statewide Quality and Equity Targets, particularly given the AHEAD model's important new all-payer approach which includes the Medicaid population. Public health agencies have extensive expertise and on-the-ground partnerships relevant to the Target domains: Population Health, Prevention and Wellness, Chronic Conditions, Behavioral Health, Maternal Health, Prevention, and Social Drivers of Health. The AHEAD framework should leverage the role of local health officers as the chief health strategist in their jurisdiction, and the multisector partnerships convened by local health departments to advance public health and health equity.

3. Statewide and local geographic coordination. Likewise, achievement of the Statewide Population Health Targets, to be determined by July 2025, will require collective action by a broad array of partners with geographic state and local coordination. The importance of significant guiding contributions by state and local public health assets to the work of achieving Population Health Targets cannot be overstated.

4. Establishes infrastructure, the Population Health Trust, to administer and monitor public and private investment. The success of the AHEAD model will require action beyond hospitals. The Population Health Trust creates an important mechanism for public and private resources to support health improvement engagement by effective and accountable public health agencies, primary care, social service providers, and others.

The HSCRC proposal describes an affordable means to launch AHEAD implementation by funding (1) new programs to address the cost and delivery of health care services and (2) a Population Health Trust to support statewide population health improvement initiatives of which public health is an essential component.

The creation of an independent fund to manage and monitor public and private investments in upstream, community-level prevention promises truly transformative outcomes. Per the State's agreement with the United States Centers for Medicare & Medicaid Services, the Trust would support activities such as reducing rates of preventable health conditions, increasing healthy habits, addressing health-related social needs, reducing or eliminating health disparities, and building evidence of effective prevention programs. The Trust provides an exceptional opportunity to leverage Maryland's unique health assets, including proven, evidence-based public health initiatives, to drive aligned, accountable, and effective collective action toward a healthier Maryland.

5. Affordable and adaptable funding mechanism. The AHEAD model's lengthy timeline of 11 years allows the opportunity to demonstrate the effectiveness of longer-term community level prevention interventions. While the specific funding mechanism as described in the proposal may not be fully achievable in certain rate years, a collaborative public/private, state/local infrastructure would be in place. Other funding sources could be tapped to support ongoing efforts.

6. Workforce investment. The proposal includes seven areas of potential investment under new programs to address health cost and delivery challenges. One area "Workforce investments, including but not limited to updates to the Graduate Medical Education (GME) program" addresses a major barrier to health equity, particularly in rural Maryland. The shortage and maldistribution of primary care residencies could be attenuated with adequate investment into new primary care training programs and practices in underserved and rural communities, resulting in significantly improved access and reduced health disparities for underserved Marylanders.

The Commission on Public Health appreciates the commitment of Governor Wes Moore and the Maryland Legislature toward advancing the health of all Marylanders. The Commission commends HSCRC's progressive policies which reflect the importance of community-based prevention, primary care, and social support along with acute care. The Commission looks forward to continuing engagement with HSCRC and the Commission on Health Equity as details of AHEAD implementation are constructed.

1. Introduction

The State of Maryland committed itself to the health of its residents shortly after it became a state in 1788. From Baltimore City establishing a health office in 1793 to stop an epidemic of yellow fever, to tackling the influenza pandemics of the 20th century, to the modern statewide efforts of battling the recent COVID-19 pandemic, Maryland has prioritized public health.

In June 2023, the Maryland General Assembly established the Maryland Commission on Public Health (the Commission) after Governor Wes Moore signed House Bill 214 into law. On the heels of the COVID-19 pandemic and other public health crises, the Commission was charged with assessing the impact of the foundational public health capabilities, the public health infrastructure of state and local health departments, and issuing a final report with recommendations to improve public health services. The Commission will make recommendations for reform in several areas, including the organization of public health departments; information technology, information exchange, and data analytics; workforce; funding; and communication and public engagement.

The Commission's assessment will:

- Review the current state of activities with recommendations that are positioned to accelerate progress towards a vision of a future where all Marylanders can achieve their full potential for health and well-being across the lifespan.
- Be conducted in the context of Maryland's relatively unique hybrid ("largely shared") governance model, health care delivery system initiatives and opportunities, and health-related programs and contributions of other Maryland agencies and commissions.
- Integrate health equity in all aspects of the assessment with a focus on our diverse population characteristics, and health and well-being needs, social determinants of health assets, and challenges.

1.1 Public Health, the Public Health System, and Foundational Public Health Services

According to the Institute of Medicine, public health is "what we do as a society to ensure the conditions in which everyone can be healthy".[II] The Public Health 3.0 framework positions health officers as chief health strategists, collaborating across sectors to leverage data and resources to enhance health and address social determinants of health.[III] Marylanders receive public health services through an interdependent ecosystem involving both public and private partners that impact community health.

Maryland Public Health System Structure, Governance, and Funding

State and local health departments lead partnerships to meet Marylanders' health needs and promote well-being throughout their lives.

The **Maryland Department of Health** (MDH) is led by the Secretary of Health and serves as the primary state-level public health agency, overseeing health programs, policies, and services to promote the health of Maryland residents. The Secretary of Health provides oversight to the development of Statewide Public Health initiatives, data review, and analysis. They guide the development of Statewide population health goals and communication with public, health officers, and stakeholders regarding public health matters. MDH has four major divisions – Public Health Services, Behavioral Health, Developmental Disabilities, and Health Care Financing.

MDH has 25 boards and commissions tasked with licensing and regulating health occupations, making recommendations on issues that affect Maryland's health care delivery system, and supporting public health projects. For FY2024, MDH's total expenditures were more than $20 billion, which included over 6,600 state merit positions.

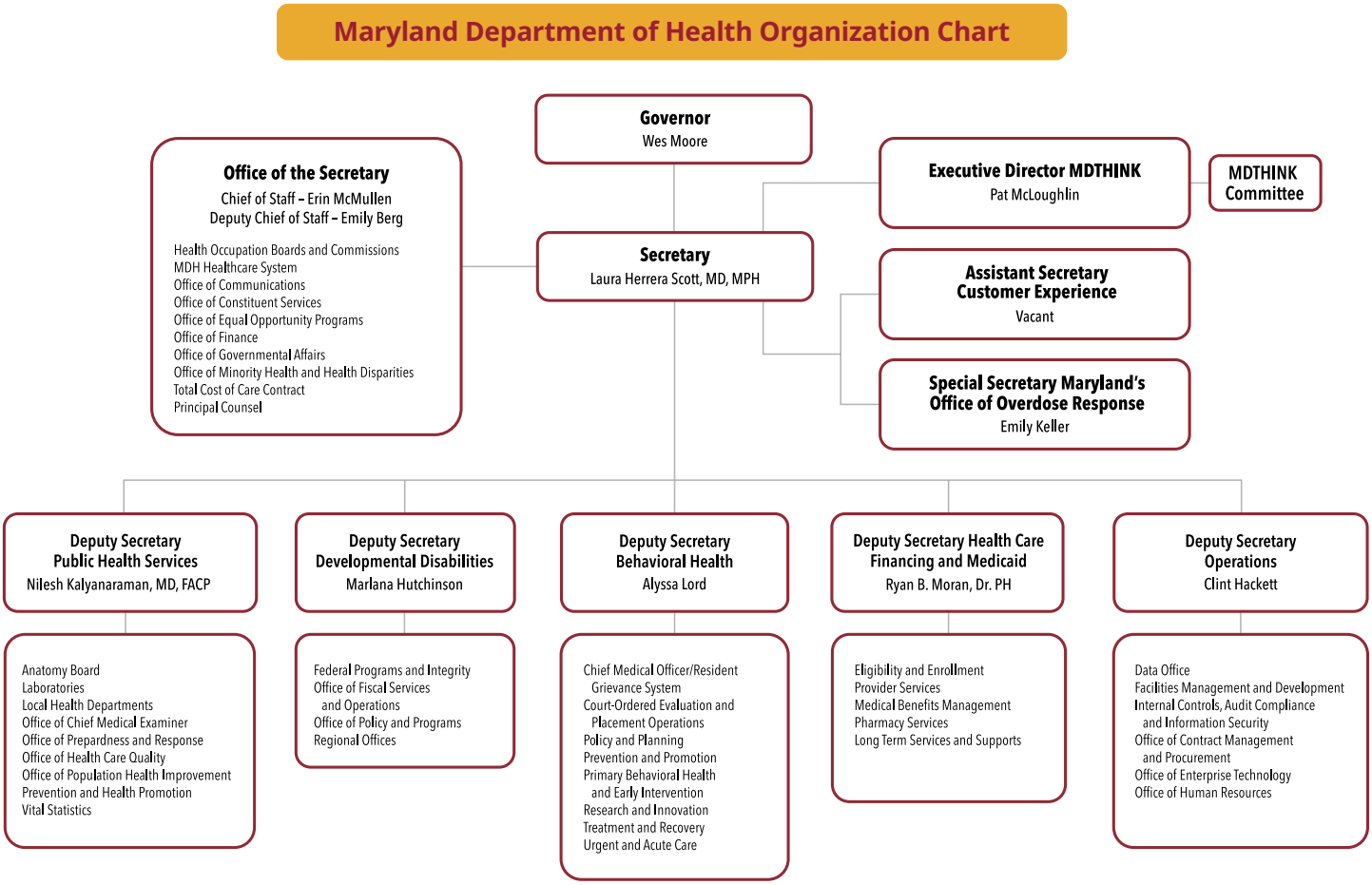


Figure 1: Overview of the MDH organization

The Maryland Department of the Environment (MDE), led by the Secretary of the Environment, also has a significant public health role, with statutory and regulatory responsibilities related to environmental health, including public health components of wastewater management, recreational water monitoring, drinking water, and air quality.

Maryland has **24 Local Health Departments** (LHDs) operating in each of Maryland's jurisdictions, including Baltimore City. All 24 LHDs have a Local Health Officer (LHO) or, in the case of Baltimore City, a Commissioner of Health. In Baltimore City, the Commissioner of Health serves in the LHO role (for the purposes of this document, the reference LHO will include the Baltimore City Commissioner of Health unless otherwise noted). Twenty-three of the 24 LHDs are led by their LHO who serves as the Chief Health Strategist for their jurisdiction and the executor/secretary for their local Board of Health (BOH). In Montgomery County, the LHO does not lead the LHD but does serve as the Chief Health Strategist who is part of an integrated Health and Human Services (HHS) department.

Authorities of the LHO are stipulated in state and local statutes, delegated by the Secretary of Health and the Secretary of the Environment, or conferred by the local Board of Health (BOH). Executive orders from the state's Governor may also directly assign responsibilities to the LHOs, for example, in times of public health emergencies. In most local jurisdictions, the elected county commissioners or county council serves as the BOH. These elected officials may have different experience or knowledge relevant to health. Maryland does not have a state board of health.

The United States Centers for Disease Prevention and Control (CDC) has classified states' public health arrangements on a continuum ranging from centralized to decentralized governance. Criteria to categorize state public health governance include the employer (state or local) of the local agency leader and the degree to which local government has authority to make fiscal decisions and/or issue public health orders. Under these criteria, Maryland's arrangement for public health governance is a 'largely shared' model. According to the Association of State and Territorial Health Officers (ASTHO), in a shared model, local health units may be led by employees of the state or local government. If they are led by state employees, then the local government has authority to make fiscal decisions and/or issue public health orders.[IV]

In addition to direct and pass-thru federal dollars, as well as private grants, LHDs rely upon a state statutorily defined state-local shared funding formula referred to as "Core Funding"[V]. A recent joint report submitted by the state's Secretary of Health and Secretary of Budget and Management at the request of the Maryland Department of Legislative Services describes the Core Funding formula factors, including the state contribution and the local match. The required local match percentage varies by jurisdiction as described in the report.[VI]

The Commission recognizes that the Maryland public health landscape is heavily influenced by federal agencies, policies, and funding. Changes in the federal landscape may have a significant impact on public health services within Maryland. The Commission is closely monitoring developments since the recent federal election and recognizes that shifts nationally may affect the capabilities of Maryland's state and local health departments.

Foundational Public Health Services

In 2022, the Public Health Accreditation Board (PHAB) updated the foundational public health services (FPHS) framework it uses to accredit health departments to include Equity.[VII] The FPHS include Foundational Public Health Capabilities (FPHC) and Foundational Public Health Areas (FPHA). The Commission's authorizing legislation includes PHAB's foundational areas and capabilities as a guide to inform its work and as a base for an aspirational vision for reimagining public health in our State. Maryland includes behavioral health as a public health priority and the Commission's authorizing legislation includes behavioral health. Thus, for the purposes of the Commission's work, the Commission has added "Behavioral Health" as a FPHA. The Commission is also required to explain the impact of the FPHC on the state's ability to address the FPHA (including behavioral health), public health emergencies including COVID-19, overdoses, maternal and infant mortality, and other public health challenges identified by the Commission.

1.2 Health Equity, Geography, and Population Health

Maryland reaches from the Atlantic Ocean to the Appalachian Mountains in the west. It borders four states and the District of Columbia. This geographic diversity reflects various occupations, weather, cultures, economies, and more. Eighteen of its 24 jurisdictions are considered rural, although most of the population is primarily

urban, especially in the Baltimore and Washington, D.C. metropolitan areas.[VIII] Rural communities exist in Western Maryland, Southern Maryland, and on the Eastern Shore. For rural counties especially, health services may be limited, and transportation remains a major challenge.

The state has a diverse population, with approximately 49.0% non-Hispanic White, 30.2% non-Hispanic Black, 6.8% non-Hispanic Asian, less than 1% American Indian and Alaska Native or Native Hawaiian and Other Pacific Islander, and 2.6% identify as two or more races. Hispanic residents are 11.1% of the population. Maryland also has a large immigrant community.[IX, X] In 2018, 15% of the population was foreign born. Maryland's age distribution shows an increase in its adult population: in 2021, there were 4,645,898 individuals aged 20 and over, compared to 4,271,653 in 2010, marking an 8.8% growth in this age group. There was a 40.9% increase among those 65 years and older making it the largest increase of any age group.

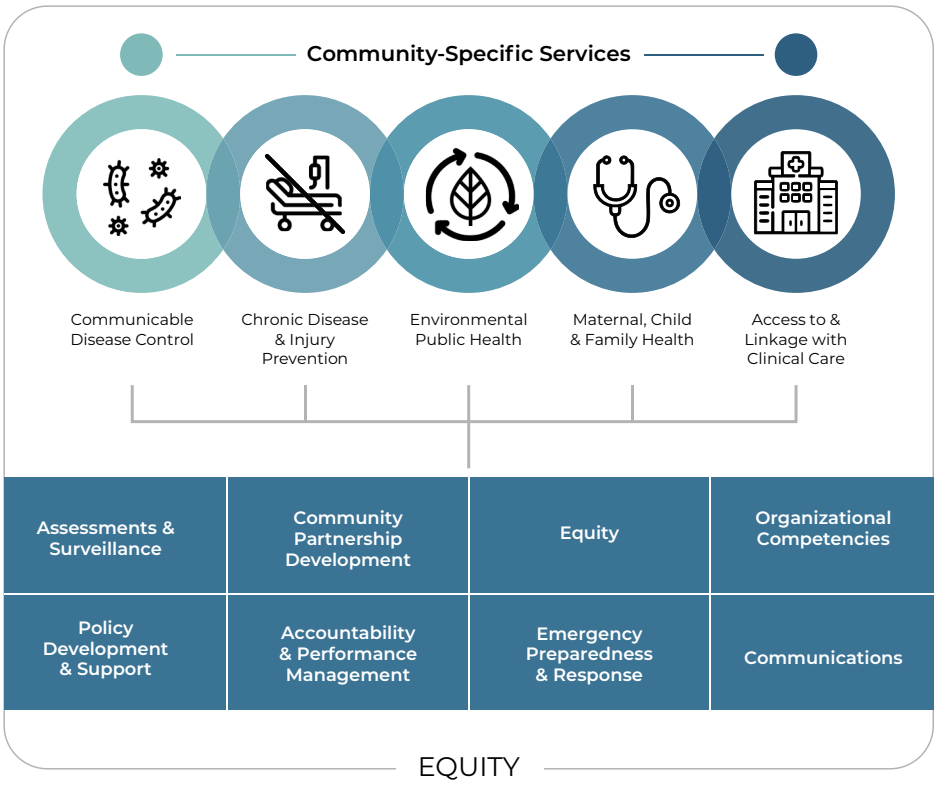


Figure 2: Foundational Public Health Services

In general, public health responsibilities and funding have evolved over the past decades to incorporate a greater focus on health equity. The U.S. Centers for Medicare and Medicaid Services (CMS) defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[XI] Several federal, including CMS and the CDC, and state agencies and their respective grant awards focus on reducing health disparities and advancing health equity in communities focus on reducing health disparities and advancing health equity in communities. Others may require consideration of health disparities as part of the grant award selection and implementation of funded activities.

CMS describes population health as the health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group. Various population identifiers could be used to describe the group, including panels of patients or members of a health plan.[XIII]

Since the last Maryland Commission on Public Health Interim Report (December 2023), Maryland's public health, population health, health equity, and health care landscape and plans have continued to expand in areas highly relevant to the Commission's charge and reflect the state's commitment to invest in Marylanders' health and well-being.

Selected highlights include:

- **May 2024:** The Community Health Resources Commission awarded 12 grantees funding to expand access to health care and address health disparities of vulnerable communities under the Health Equity Resource Communities Program. The grantees were collectively awarded $41.5 million to address social determinants of health, improve health disparities, increase primary care, and positively impact health outcomes.
- **July 2024:** The state's Health Services Cost Review Commission (HSCRC) received CMS's Advancing All-Payer Equity Approaches and Development (AHEAD) award notice. The state agreement with CMS focuses on improving population health, advancing health equity by reducing health disparities, and curbing growth in healthcare cost spending. Maryland will build upon the existing Maryland Total Cost of Care initiative and the Maryland Primary Care Program. The AHEAD implementation period will begin on January 1, 2026. Maryland will use 2025 to prepare for implementation. In November 2024, HSCRC proposed a draft recommendation for 2025 funding of AHEAD preparation. As outlined at the beginning of this report, the Commission has recommendations for how AHEAD might align with the public health system outlined at the beginning of this report.
- **September 2024:** MDH released the State Health Assessment and State Health Improvement Plan (SHIP) conducted as part of the Building a Healthier Maryland initiative. The SHIP presents goals, objectives, and strategies for five priority areas: chronic disease, access to care, women's health, violence, and behavioral health.
- **October 2024:** House Bill 1333 "Public Health – Maryland Commission on Health Equity and Commission on Public Health - Revisions" signed into law for the purpose of requiring the Maryland Commission on Health Equity to develop and monitor a statewide health equity plan; requiring the Maryland Commission on Health Equity to coordinate with MDH and the HSCRC when establishing an advisory committee; altering the reporting requirements for the Commission on Public Health; and generally relating to the Maryland Commission on Health Equity and the Commission on Public Health. Consequently, the Commission shall submit an interim report on December 1, 2023; a (final) interim report of its findings and recommendations on or before December 1, 2024; and final report of its findings and recommendations on or before October 1, 2025.[VII]
- **October 2024:** The Maryland Commission on Health Equity (HB 1333) held its first meeting to develop the statewide health equity plan. The creation of this plan addresses the cross-cutting capability of "equity" of the FPHS framework.[VIV]
- **October 2024:** During the last legislative session, the Department of Legislative Services requested a report to clarify funding streams for local health departments. The Report on Core Public Health Services

Funding for Maryland's LHDs: 2024 Joint Chairman's Report was released, and legislators had until November to respond.

- **Throughout 2024:** The Maryland Commission on Behavioral Health Care Treatment and Care has continued to pursue its four-year charge to develop "appropriate, accessible, and comprehensive behavioral health services" statewide across the behavioral health continuum of care. Workgroups are exploring population-focused care needs and workforce, infrastructure, and financing issues. Their findings will inform the Commission's deliberations on the behavioral health aspects of public health.
- **Before 2026:** The MDH – Health Commissions and Maryland Insurance Administration – Study (HB 887) calls for an independent contractor to study, and report by January 1, 2026, "the overlap of the statutory and regulatory duties performed by the HSCRC, the Maryland Health Care Commission, Maryland Community Health Resources Commission, and the Maryland Insurance Administration." Recommendations are to be made on "whether and how" the duties can be streamlined, "whether and how the functions" could be "better aligned to improve effectiveness and efficiency," and "whether there are duties that may be more appropriately performed by MDH or another commission or agency." In addition, the study will look at how the commissions are aligned with the Maryland Total Cost of Care model and the State's participation in the Advancing All-Payer Health Equity Approaches and Development model.[VIV]

These selected directives and initiatives demonstrate health and well-being-related state activities that are relevant to the work of the Commission. Several Commissioners and workgroup members are active participants in these activities, which fosters cross-communication and collaboration.

Additionally, the presidential and congressional elections and their impact on public health policy and funding leave many future unknowns. The Commission will continue to closely follow these and other developments and work with legislators and all partners to provide timely expertise as it prepares its final report.

2. Commission Activities to Date

2.1 Introduction

The Commission is approaching its purpose via a three-pronged approach. The first prong of the approach is **ASSESS**. The Commission is assessing the state and local public health system through multiple quantitative and qualitative tools. After completion of the assessment phase, the Commission will **ARTICULATE** the desired future for public health capabilities in Maryland and, through inclusive and spirited inquiry, develop recommendations to improve the delivery of foundational public health services. It will be up to state and local leaders, as well as others in the public health system, to **ADVANCE** the Commission's recommendations.

Per legislation, membership of the Commission consists of:

- One Senator
- One Member of the House of Delegates
- The MDH Deputy Secretary for Public Health Services or designee
- The MDH Deputy Secretary for Behavioral Health or designee
- The MDH Director of the Office of Minority Health and Health Disparities or designee
- Three Local Health Officers from rural, suburban, and urban jurisdictions
- Two Representatives from State academic institutions with expertise in public health systems
- One Faculty Member from a public health program at a historically Black college or university
- Three to five members of the public with a demonstrated interest in public health and experiences in health equity, information technology, workforce, or population health

See Appendix 5.1 for the full list of members as of December 1, 2024.

2.2 Commission Engagement

In December 2023, the Commission submitted its initial interim report to the Governor, Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health and Government Operations Committee.

Key organizational partners of the Commission include the CDC Foundation, the Maryland Association of County Health Officers (MACHO), University of Maryland School of Public Health, Morgan State University School of Community Health and Policy, and the de Beaumont Foundation. Johns Hopkins University Bloomberg School of Public Health also provided in-kind staffing to support the work of the Commission during fiscal year 2024.

The Commission has met 12 times since its first meeting in December 2023. The public is notified in advance and invited to all meetings in person or virtually. Meetings are also recorded and posted online at the Commission's website smchd.org/coph.

The co-chairs, Drs. Meenakshi Brewster, Boris Lushniak, and Oluwatosin Olateju, arranged for guest speakers at Commission meetings and guided the commissioners' discussions on the topics highlighted in the statute.

Outside of the Commission meetings, the co-chairs met quarterly with the Secretary of Health, had weekly executive meetings, met monthly with the workgroup leaders, and held monthly meetings with the MDH Deputy Secretary of Public Health Services.

Commission co-chairs, some workgroup members, and the Commission support team participated in a site visit to meet with leadership at the Indiana Department of Health and Indiana University Richard M. Fairbanks School of Public Health to learn about the public health transformation process utilized by that state. The Commission also joined Public Health Accreditation Board 21st Century Learning Community (PHAB 21-C) and attended the PHAB 21-C annual meeting.

Commissioners and workgroup members have discussed the work of the Commission at major national and state events, including: an American Public Health Association meeting (Oluwatosin Olateju), Maryland State of Reform event (Meenakshi Brewster and Craig Behm), National Governor's Association/CDC Foundation event (Meenakshi Brewster and Judy Monroe), the National Association of County and City Health Officials Annual Meeting (Meenakshi Brewster and Ruth Maiorana).

The Commission has had a variety of experts present on timely topics during monthly commission meetings to help inform the activities and conversations of the Commission. Full recordings of presentations and meeting materials are available online. **These presentations include:**

- *Indiana's Process* – Dr. Judith Monroe, President and CEO, CDC Foundation
- *Overview of Maryland's Local Public Health Infrastructure* - Bob Stephens, Health Officer, Garrett County President, Maryland Association of County Health Officers (MACHO)
- *Overview of Maryland's State Public Health Infrastructure* – Dr. Nilesh Kalyanaraman, Deputy Secretary of Public Health Services, Maryland Department of Health
- *Public Health System Assessments and Transformation Approaches* - Reena Chudgar, Senior Director, Public Health Systems and Services Public Health Accreditation Board; Jessica Solomon Fisher, Chief Operating Officer, Public Health Accreditation Board
- *CRISP State-Designated Health Information Exchange (HIE) - Overview and Services* - Craig Behm, CEO, Chesapeake Regional Information System for our Patients (CRISP)
- *Behavioral Health* - Alyssa Lord, Deputy Secretary of Behavioral Health, Maryland Department of Health
- *Overview of Health Services Cost Review Commission (HSCRC)* - Dr. Joshua M. Sharfstein, Vice Dean for Public Health Practice and Community Engagement, Johns Hopkins Bloomberg School of Public Health MDH Population Health Transformation Advisory Committee
- *2023 MHHD Annual Report Findings* - Camille Blake Fall, Director, Office of Minority Health and Health Disparities, Maryland Department of Health
- *Collaboration Between Public Health and Healthcare Delivery* - Chelsea Cipriano, Managing Director, Common Health Coalition
- *Overview of the Maryland Health Care Commission* - Ben Steffen, Executive Director, Maryland Health Care Commission

- *State of Maryland Department of Health (MDH) and Priorities* – Dr. Laura Herrera Scott, Secretary, Maryland Department of Health
- *Strengthening Maryland's Safety Net and Advancing Health Equity* - Mark Luckner, Executive Director, Maryland Community Health Resources Commission
- *Overview of Rural Health in Maryland* - Jonathan Dayton, Executive Director, Maryland Rural Health Association
- *Building The Next Generation Public Health System* - Georges C. Benjamin, Executive Director, Maryland Community Health Resources Commission
- *Maryland Primary Care Program (MDPCP)* - Chad Perman, Executive Director, MDPCP Management Office
- *Workforce Panel* – Dr. Ann T. Kellogg, Director of Reporting Services, Maryland Longitudinal Data System Center and Maryland Higher Education Commission; Dr. Crystal DeVance-Wilson, Assistant Professor, University of Maryland School of Nursing; Dr. Nganga-Good Deputy Director, U.S. Department of Health and Human Services, Health Resources Services Administration (HRSA), Health Systems Bureau
- *Equity, Diversity, and Inclusion A Cornerstone in our Cultural Evolution* - Dr. Roderick King, Sr. Vice President and Chief Equity, Diversity, and Inclusion Officer, University of Maryland Medical System
- *State Health Improvement Plan* - Dr. Katherine Feldman, Chief Performance Officer, Maryland Department of Health

Workgroups

The Commission has five workgroups required by its authorizing statute. These workgroups are a mechanism of broad engagement in the Commission and expert input into the work and recommendations of the Commission.

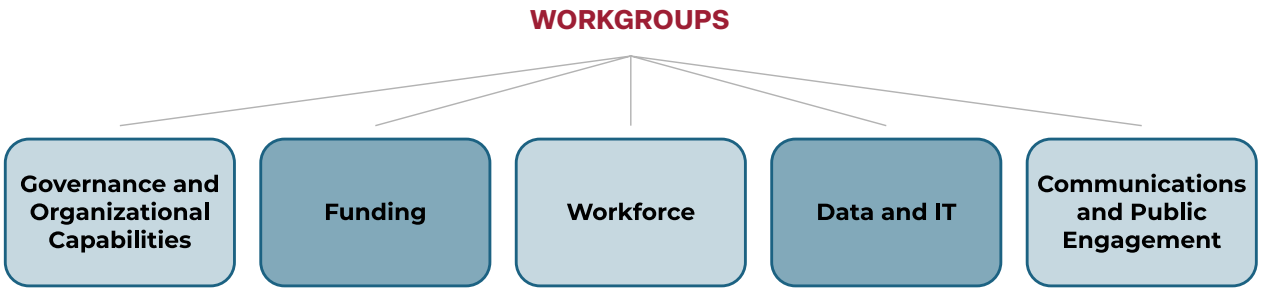


Figure 3: Commission workgroups

A sixth topic area though not a workgroup is "procurement including oversight of contractors" which will be incorporated into the charge of all five workgroups to consider as they consider recommendations for their topics.

The Workgroups include a broad array of Commission and public members representing different disciplines, practices, public, private, and non-profit experiences, and geographic perspectives. (See Appendix 5.2 for the full list of members.) The Workgroup Co-Chairs convene their groups and/or subcommittees monthly to maintain member engagement and ensure sufficient time to incorporate expert testimony, facilitate rich discussion, and generate well-crafted recommendations.

The Workgroups each have a charter and are charged with performing a critical review of existing documents, reports, literature, and data, hosting informed discussions with relevant leaders, and gathering lessons learned from peer states and relevant associations. They were asked to:

- Assess and analyze the Maryland public health system at all levels
- Define current and future state gaps, opportunities, and vision for the future
- Collaborate with other workgroups as needed
- Identify exemplary states, best practices, and other innovations to be studied
- Host speakers and subject matter experts from across the country to help inform the analysis
- Identify stakeholders, key informants, and other relevant data to inform the Commission's work
- Track themes and incorporate them into assessment
- Draft workgroup sections of the final report based on the template/format outlined by the Commission, including findings
- Assist with editing and reviewing reports

All workgroups will explore the content assigned to them in addition to discussing and analyzing how the cross-cutting themes in Figure 4 interact or impact their specific areas.

- **Integration of Behavioral Health, Clinical Medicine, and Public Health**
- **Procurement and Contractor Oversight**
- **Infant Mortality Rates**
- **SUD/OUD-Related Deaths**
- **Health Equity**
- **COVID-19 Response** (and general emergency preparedness)
- **Maternal Mortality Rates**
- **Other Public Health Issues/Areas of Concern**

Figure 4: Workgroup Cross-Cutting Themes

Workgroup Activity

Workgroup	Governance and Organizational Capabilities	Funding	Workforce	Data and Information Technology	Communication and Public Engagement
Workgroup Specific Charge	Accountability and performance management Identify and make recommendations for organizational competencies Identify primary lead for FPH area recommendations and implementation Address linkage to clinical care concerns/challenges Consult with Department of General Services and Department of Management & Budget Study organization of state and LHDs	Document investments in both FPH capabilities and FPH areas Document funding for each FPH area Identify ways to maximize funding flexibilities while promoting fiscal transparency Identify ways to reduce process friction for procurement, contracting, and other administrative processes Integrate community health benefit and other plans into broader public health system Consult with Department of Management & Budget	Identify the diversity of the public health workforce Review and analyze public health WINS and other data sets to identify trends Review workforce in context of FPH areas, especially access to behavioral and primary care Make recommendations for talent development pipelines, recruitment, retention, and onboarding processes Improve Medical Reserve Corps recruitment and processing	Characterize assessment and surveillance systems capabilities and limitations Make recommendations on cybersecurity, protection of data, system integration and maintenance Assess system capabilities of LHDs Make recommendations to improve systems, especially centralized administrative systems/ software Identify procurement and contractor oversight challenges as pertains to systems and projects	Identify communication channels preferred and used by the public Assess the effectiveness of public health outreach and messaging Assess engagement of the public and community-based partners in public health work Identify ways to improve health literacy, cultural humility, and accessible resources Identify best practices for maintaining inclusion and engagement from the public in public health policymaking
Activities	Monthly meetings Attendance at site visits and listening sessions Outreach to other state agencies to speak to workgroup or inform the process	Monthly meetings	Monthly meetings Attendance at site visits and listening sessions Invited speakers from other states and relevant entities	Monthly meetings Conferences: National Association of County and City Health Officials (NACCHO) 360	Monthly meetings Surveys: Maryland Association of County Health Officers (MACHO) Public Information Officers Group Conferences: Association of Schools and Programs in Public Health

Workgroup	Governance and Organizational Capabilities	Funding	Workforce	Data and Information Technology	Communication and Public Engagement
Meeting Presentations	Jon Kromm, Executive Director, Maryland HSCRC Mary Bearden, Sr. Counsel, Maryland Office of the Attorney General Indiana Department of Health staff	Overview of Public Health Funding - Dr. Laurence Polsky, Medical Director, Calvert County Health Department Core Funding - Rebecca L. Jones, Health Officer, Worcester County Health Department State of Maryland Public Health Overview - David Davis, Director of Operations, MDH Public health grant management - Michelle Moore, Director of Grants and Local Health Accounting, MDH and Irma Bevins, Advisor of Grants and Local Health Accounting, MDH Community Benefits - Dr. Hossein Zare, Associate Research Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health Community Benefits - Brian Sims, Vice President of Quality & Equity, Maryland Hospital Association Community Benefits - Megan Renfrew, Deputy Director of Policy & Consumer Protection, Maryland HSCRC Philanthropy Funding and Public Health - Elisabeth Hyleck, Vice President of Programs & Engagement, Maryland Philanthropy Network; Liz Tung, Program Officer for Health & Human Services, Abell Foundation; Glenn Schneider, Chief Program Officer, The Horizon Foundation	Dr. Allison Chamberlain, Research Associate Professor, Department of Epidemiology Director of Research and Practice Relations with Georgia DPH, Emory University Rollins School of Public Health Shelby Rentmeester, Director of Rollins Epidemiology Fellowship Program, Emory University Rollins School of Public Health Dr. Heather Krasna, Adjunct Assistant Professor of Health Policy & Management, Columbia University Mailman School of Public Health	Dr. Brian Dixon, Director of Public Health Informatics, Regenstrief Institute, Inc. and Indiana University Richard M. Fairbanks School of Public Health	Commission on Public Health Charge - Dr. Oluwatosin Olateju, Assistant Professor of Nursing, Coppin State University Maryland Foundations for Community Engagement & Communications - Dr. Cynthia Baur, Endowed Chair and Director of the Horowitz Center for Health Literacy, University of Maryland The Composition, Role and Challenges of Communications Within Local Health Departments- Maggie Kunz, Health Planner, Carroll County Health Department Melissa Stoker, Digital Media Manager, MDH The Commission's Workgroup Charters and Timeline - Shane Hatchett, Principal and Founding Member, Advent Solutions

Workgroup	Governance and Organizational Capabilities	Funding	Workforce	Data and Information Technology	Communication and Public Engagement
Resources Consulted	Network for Public Health Law Public Health Accreditation Board National Academy for State Health Policy Bipartisan Policy Center CDC Peer states: Washington, Colorado, Tennessee, Indiana	Articles in peer-reviewed literature on Community Benefit funding Research on public health funding in other countries	Consulted experts in the workforce space Reviewed numerous articles from Health Affairs Used the Indiana Workforce Report as a model		Four Interns spent 200 hours reviewing 50 articles
Next Steps	Continue monthly meetings with invited speakers Adapt our work to input received from other workgroups Review findings of the assessments for direction regarding governance and organizational capabilities issues Include MDH partners in future fact finding to ensure a balanced perspective Examine MDE's relationship with MDH and LHDs with special attention to governance and organizational capabilities	Invite expert speakers from Maryland Medicaid to address the workgroup Complete additional research to improve utilization of grant funds at both the state and local levels Determine opportunities to fund the identified priorities/ recommendations of the Workforce and IT/Data work groups	Conduct a focus group with front-line workers Conduct a focus group with LHOs Review, analyze, and summarize Public Health Workforce Interests and Needs Survey (PHWINS) data from all health departments Assess NACCHO Profile data	Continue to invite expert speakers from CDC and other agencies/jurisdictions Review findings of the assessments	Survey the public Determine what communication channels are being used by the public and which channels they trust Assess funding for social media and marketing Determine the influencers and partner with them

2.3 System Engagement

The Commission's work has been categorized into three lines of effort in alignment with the enabling statute: system engagement, public engagement, and system assessment.

The Commission has heard from several experts about Maryland's public health systems and similar systems in other states. These experts have engaged either continuously as Commission or workgroup members or have given special presentations at Commission or workgroup meetings. At monthly meetings, the Commission generally invites at least one guest speaker from national and regional experts on public health. The Commission has also heard from state and local partners to help inform its understanding and assessment of the public health system today.

The Commission completed six LHD site visits in different regions of the state to better understand the needs and dynamics of local public health services and how they may vary jurisdiction by jurisdiction. The host LHDs invited commissioners, workgroup members, and commission support team members to participate.

2.4 Public Engagement

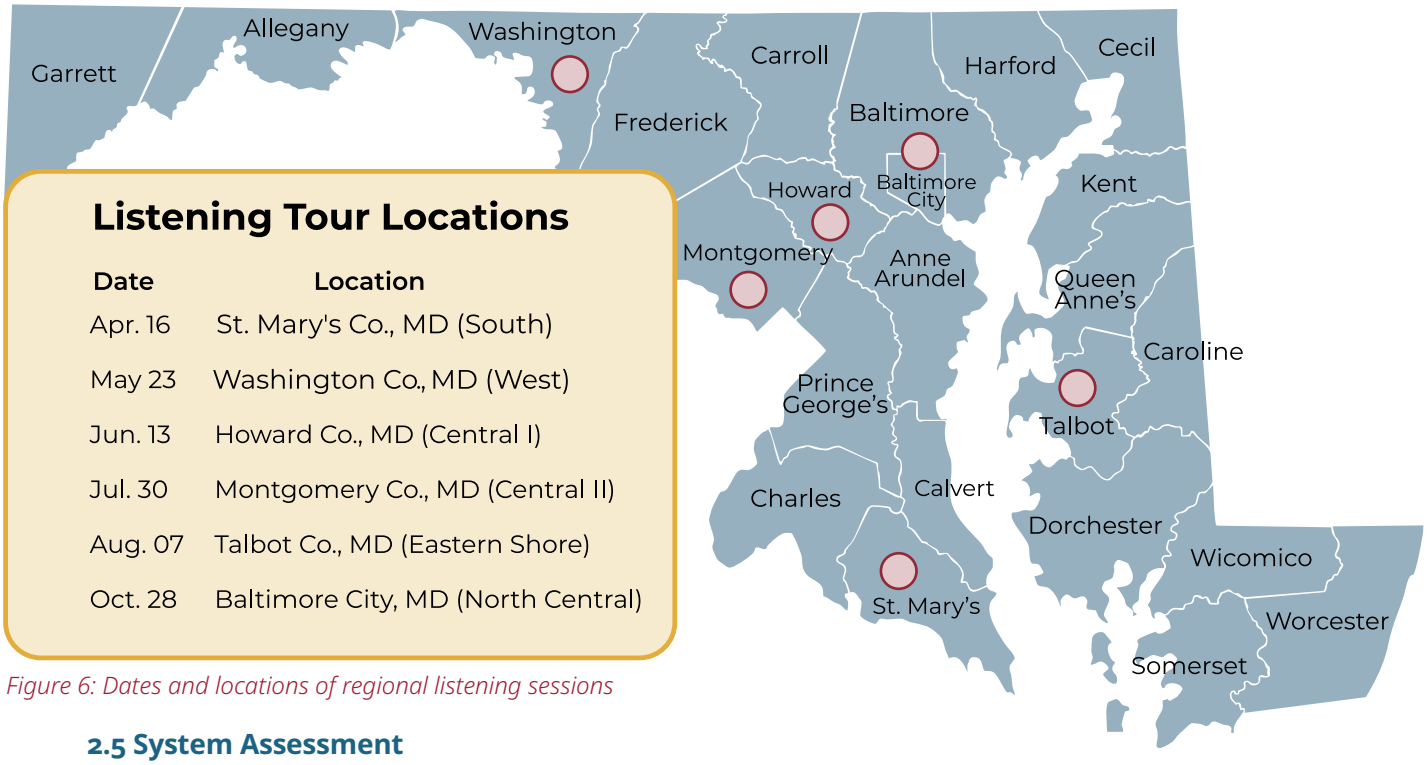
The Commission created an accessible online mechanism on its website to capture written public input and established a voicemail at which members of the public could leave spoken input. These mechanisms of public input have taken place over several months of 2024.

The Commission's Workgroup on Communications and Public Engagement also created a public survey to better understand where Marylanders get their public health information, their trust of Health Department information, the channels from which they prefer to get information, and other sources of information they trust in the Maryland public health space. The Commission established LinkedIn, YouTube, and Instagram accounts to broaden its reach and ensure that Marylanders can stay informed and involved in this process.

The Commission hosted six regional public listening sessions to learn from community members in various geographic locations. These sessions began in April 2024 and continued through October 2024. Citizens, providers, advocates, and other

Figure 5: Public survey to obtain input from Maryland citizens

stakeholders attended the sessions in person and offered testimony. Figure 6 shows the dates and locations for the regional listening sessions. Most sessions were limited to in-person feedback due to technological limitations, but Howard and Montgomery Counties were able to allow hybrid formats. St. Mary's County reached out to its Amish population in-person separately to offer another opportunity for input. All regional public listening sessions were live-streamed and the recordings were posted online.



Listening Tour Locations

Date	Location
Apr. 16	St. Mary's Co., MD (South)
May 23	Washington Co., MD (West)
Jun. 13	Howard Co., MD (Central I)
Jul. 30	Montgomery Co., MD (Central II)
Aug. 07	Talbot Co., MD (Eastern Shore)
Oct. 28	Baltimore City, MD (North Central)

Figure 6: Dates and locations of regional listening sessions

2.5 System Assessment

A "Conceptual Model for the Maryland Commission on Public Health" was developed to guide the Commission's assessment. This model is underpinned by the Evidenced-Based Public Health (EBPH) model.[XIV]

To supplement its meetings, Workgroup deliberations, public input, and LHD site visits, the Commission has initiated an additional set of assessment activities. The Assessment Team includes fiscal and personnel support from the CDC Foundation, universities, and national health experts. This team is interviewing key informants and stakeholders, facilitating focus groups on key topics relevant to the statute, analyzing existing surveys and input from online public comments and listening sessions, and implementing an organizational survey of state and local health departments.

Additionally, ASTHO and the de Beaumont Foundation, in partnership with MDH, are implementing an updated version of the national Public Health Workforce Interests and Needs Survey (PH WINS) that will, for the first time, include representation from MDH state-level staff as well as all staff at the 24 LHDs. The de Beaumont Foundation will also conduct workforce conversations with MACHO and front-line public health workers. Early findings are expected in February 2025.

The questions in the assessment cover:

- Public health department organizational structure
- Workforce and recruitment
- Partnerships
- Funding
- Data and Information Technology (IT) infrastructure
- Internal and external communication
- Emergency preparedness and readiness
- Health Equity
- Visions for the future
- Constituent needs

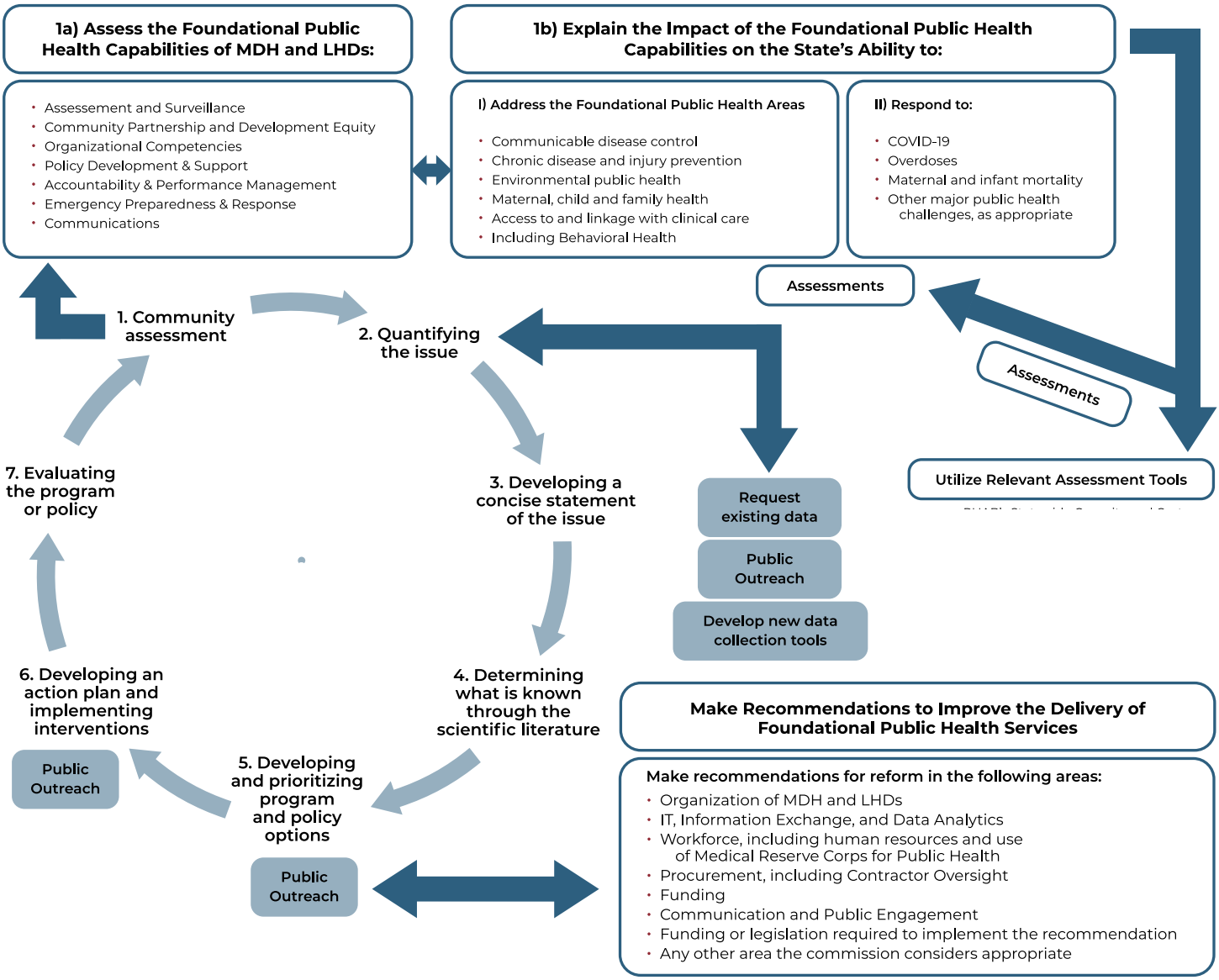


Figure 7: Conceptual Model for the Maryland Commission on Public Health | February 2024

Informed by Evidence-Based Public Health (EBPH) model adapted from Brownson[XVI] RC, et al. 2009; Annu. Rev. Public Health. 30:175-201; and the FPHS and Capabilities per the legislation.

Upon completion of the Assessment Team's work, the Commissioners and Workgroup members will articulate the desired future for public health capabilities in Maryland and, through inclusive and spirited inquiry, develop recommendations to improve the delivery of foundational public health services. The development of initial recommendations will be an iterative process informed by Commission discussions and honed through a public review process.

Project Partners	Role
Commission	Assess the foundational public health capabilities of state and local health departments and analyzing the state's ability to respond to major public health challenges
Commission Co-Chairs	Leadership of the Commission
Work Groups	Provide expertise to inform direction of the commission, assessment, etc.
Work Group Co-Chairs	Leadership of the Work Groups
Maryland Department of Health (MDH)	Advisory Role
St. Mary's County Health Department	Website and communication support. Staffing and resource support
Maryland Association of County Health Officers (MACHO)	Assessment support, advising
CDC Foundation	Resource mobilization, work group support and staffing, contractor support, project management support
de Beaumont Foundation	Work group support and staffing, assessment support
Morgan State University, School of Community Health and Policy	Assessment support and workgroup support
University of Maryland, College Park, School of Public Health	Assessment support, advising
Coppin State University	Commission and staff support
Shane Hatchett, Advent Solutions, LLC	Commission management, workgroup support

Figure 8: Entities supporting the assessment efforts of the Commission

3. Emerging Issues

In its final report, the Commission will "make recommendations to improve the delivery of foundational public health services" in the state per HB 214. These emerging thoughts are preliminary because the Commission is still early in the stages of Assessment. Assessment components thus far have included workgroup/commission speakers, research and discussion by workgroup professionals, LHD site visits, and regional public listening sessions. Thus, the "emerging thoughts" do not reflect the breadth and prioritization of the final recommendations of the Commission.

3.1 Commission Assumptions

The Commission has been operating with a common understanding that:

- Key elements of effective governmental public health operations require clear governance and organizational structures; a skilled, diverse, and prepared workforce (with a stable pipeline plan); timely data and information technology availability and resources; sufficient funding: state and local governmental funds and external funds; and clear communication and sustainable public and community engagement and partnerships
- Addressing the State's diverse public health regional and county-specific needs and health care capacity, geographic differences (rural, urban) with vast differences within local communities, and rapidly growing variation in the population's sociodemographic characteristics will require flexibility in approaches and human, fiscal, and technological resources
- Maryland's public health governance includes a largely shared governance model between the state and local health departments, but also is intricately linked with other state and county agencies that contribute to operational capabilities (policies, practices, procedures) and the ability to improve public health services
- The MDH and LHDs provide essential leadership for the state's public health system, and are a critical component of the state's health and healthcare continuum of activities: the only component with a principal focus on the public's health (health promotion and disease prevention of communities and populations)
- Maryland's continuing investments in value-based innovative healthcare delivery systems reform, now including the AHEAD model (population health, health equity, all-payor, primary care), provide a timely opportunity for collaboration and coordination between public health and primary care and healthcare delivery systems on behalf of the public's health and for the benefit of all Marylanders
- An equity lens is essential to the Commission's review of the impact of FPHC on the state's ability to address the FPHA and community-specific services, including those related to behavioral health, at the state and local levels. In addition, the Commission will explain the impact of FPHC on the state's ability to respond to COVID-19, overdoses, maternal and infant mortality, and other major public health challenges as appropriate.

The Commission will develop both short-term and long-term recommendations that will result in a roadmap that will serve as the foundation for a more robust Maryland public health system.

3.2 Commission's Framing Questions

As part of the charge to the Work Groups, the Commission has drafted initial framing questions to guide assessment and the articulation of recommendations. For purposes of these Framing Questions, "health departments" refer to MDH and the 24 LHDs. As the Commission's authorizing legislation specifically calls upon the Commission to conduct the assessment of the state and local health department, the framing questions are geared towards an understanding of these entities. However, the public health system as previously described is an interdependent system of multiple public agencies beyond health departments, as well as a variety of other public and private partners at state and local levels. A thorough assessment of Maryland's public health capabilities should assess the various elements of this multisectoral system. However, given limitations of time, resources, and language of the authorizing legislation the Commission's current assessment primarily addresses state and local health departments.

Health Equity: How is equity addressed, integrated and measured in all aspects of the foundational public health services (including behavioral health) and in the organizational capabilities? What is needed to build the capacity to address health equity?

Health-related Communication with the Public: What approaches do health departments use to keep the public informed about health issues? What barriers exist to translating science into effective messaging? How does the recent rise in misinformation impact the ability of public health professionals to communicate? In a rapidly changing health information environment, what are the best ways to communicate and share actionable information with the public and get meaningful input from the public?

Establishing and Nurturing Community-based Public and Private Partnerships: To what extent have partnerships been developed to enhance the health departments' capacity to fulfill their missions? What are best practices for meaningful community partnerships and public engagement?

Workforce Development: How well are health departments able to recruit, hire, develop and retain the diverse workforce needed to execute their mission? What challenges related to workforce development have health departments experienced? What are the public health workforce and senior leadership needs? What approaches and partnerships can enhance workforce availability, capacity, readiness and skills for today's and tomorrow's public health challenges?

Emergency Preparedness and Readiness: How prepared are communities to respond to an emergency or public health crisis? What are the advantages and disadvantages of the current system in terms of readiness and emergency preparedness? What resources can be mobilized to support and enhance the effectiveness of emergency preparedness and response and the Medical Reserve Corps?

Governance and Structure: Are health departments organized and able to fulfill the foundational public health capabilities? How is the Maryland model of shared governance working? What key elements of the governance and organizational capabilities of MDH and LHDs can be enhanced or modified to improve and accelerate the delivery of FPHS including behavioral health)?

Financial Resources and Allocation: How sufficient are the financial resources provided to health departments to fund work in the foundational public health areas as well as other high priority initiatives? What challenges are experienced with respect to the procurement and spending of grant dollars? How could the procurement processes and contractor oversight at the state and local level be improved to promote

accountability, and the efficiency and effectiveness of public health service delivery? In what ways could additional funding be used to fill critical needs? How can funding be optimized and made more flexible to deliver improved public health services for today's and for tomorrow's challenges?

Data and IT Infrastructure: How are data being used to understand the health needs of state and local communities? What impediments exist to access and use data to drive strategic planning and evaluation of public health activities? What key data, data analytics and IT issues, if addressed, could maximize assessment and surveillance, public health planning, accountability, performance management and effective and efficient collaboration with the health care delivery system?

3.3 Emerging Issues

3.3.1 Maryland Demographics and Landscape

- The State has experienced changing population trends over the past several decades. Most jurisdictions have significant variation in demographics and health challenges.
- The State has diverse regional and county-specific health needs and health care capacity, geographic differences (rural, urban) with vast differences within local communities, and a rapidly growing variation in the population's sociodemographic characteristics.
- While Maryland is generally regarded as having better-than-average health outcomes in aggregate, communities experience varying levels of health attainment which results in disparities that often appear along socio-economic and racial lines.

3.3.2 Governance and Organizational Capabilities

- There is a need for clarification and consistent understanding of state and local authorities and responsibilities, especially as it relates to issues of legal representation, delegated authority under statute and other governance matters.
- LHOs do not feel sufficiently engaged in organizational policymaking for state health or environmental policies that may impact LHDs.
- LHOs expressed a need for a strong hub for state/local exchange; practice, policy, and workforce innovation; and a gateway for research collaborations.
- Local Boards of Health (BOHs) appear to be underutilized as a resource and vary in purpose, composition, and performance.
- Local BOHs do not always represent the breadth of diversity in communities.

3.3.3 Funding

- The Core Funding formula does not adequately or equitably serve current public health needs and changing demographics. The original basis for determining the percentage match for each county is uncertain. The current match rates were put into place nearly 30 years ago and do not reflect well the current needs of communities.
- State financial management systems do not meet the needs of a modern organization and create administrative challenges as personnel are required to adapt to processes that are not efficient or contemporary.

- Complexity of grant oversight and administration delays program implementation and often leads to funds returning to the granting agency. This results in lost program dollars and unmet needs.
- When funding remains static, available funding needed to maintain vital programs and support salaries is eroded.
- Service location impacts the level of reimbursement for certain types of services (e.g., Medicaid reimburses Federally Qualified Health Centers [FQHCs] at higher levels than those paid to LHDs that provide direct clinical services such as behavioral health, reproductive health, etc. even though LHDs serve the same income levels as FQHCs and have similar financial pressures to maintain access to care for the public).
- Public health programs often impact multiple sectors and therefore require engagement across different state (e.g., Maryland Department of Education, Department of Transportation, Department of Social Services, etc.) and local (e.g., educational institutions, law enforcement, etc.) agencies to be effective and efficient.
- LHD programs were generally successful and sustainable when they used braided funding and community partners to force-multiply the LHD's resources.

3.3.4 Workforce

- The data collection efforts around public health workforce are hampered by the ways in which the workforce is categorized by occupational codes and academic classifications.
- Collaboration between local public health and academic programs is often ad hoc and does not consistently lead to pathways of experiential learning and employment within the state.
- Variation in salaries and growth opportunities across the state and other sectors often pull professionals out of the field.
- Geographic issues and length of funding cycles can compound workforce challenges as they relate to rural areas and grant-funded positions.
- Restrictions and oversight on staff augmentation hamper the ability of state and local leaders to quickly launch programs and address short-term needs.
- State systems provide economies of scale, but do not reflect a modern approach to recruiting and talent acquisition.
- The types and quantity of positions vary by health department based on need and resources. Yet to deliver FPHS, all core competencies are still required at the local level.

3.3.5 Data and IT

- Accurate, accessible, and efficient data are crucial for informing public health policies, surveilling and managing outbreaks, and improving community health outcomes.
- Electronic Health Records (EHRs) play a crucial role in promoting public health, but also pose challenges around precision in data collection and reporting, integration across other data systems, redundancy and inconsistencies, and privacy.
- Health outcomes and policymaking are hampered by outdated privacy laws and regulations that do not contemplate the level of connectivity of a 21st century world.

- The rapidly changing IT and data ecosystem is insufficiently resourced to undergo regular updates and keep pace with innovation. As the gap between the present and future states widens, these efforts require major modernization efforts that can be costly and disruptive.
- Data systems and their outputs are not always designed to promote transparent, accessible, and equitable external communication that meets the diverse needs of communities.
- Race and ethnicity data are regularly missing, incomplete, or inconsistently defined across different data systems and organizations.
- Artificial intelligence is an emerging field and has the potential to transform public health. It also presents challenges that require the development of a regulatory framework that ensures the accuracy of information, is overseen by qualified professionals, and promotes responsible use in analysis.

3.3.6 Communication and Public Engagement

- Disinformation and mistrust of traditional public health communications is extremely high. The vast number of health information sources and online media do not always reflect current or accurate information.
- Effective communication and engagement are essential for any public health intervention. It is difficult for governmental public health to keep up with emerging media technology.
- Health promotion, communications, and marketing are under-resourced and are not always an allowable expense or item in grant applications. Public health communications competencies do not explicitly align with marketing and promotion strategies required to engage the public.
- The public is rarely aware of the full breadth of public health and how it impacts them. Public health entities are often not successful in explaining their role and work in ways that resonate with the general public, policymakers, and elected officials.
- Public health information is not regularly presented in ways that are relatable to the community being served, especially for areas with unique language needs or varying reading levels.

4. Next Steps

Analysis of Primary Data

The Assessment Team continues to collect data from interviews, surveys, and focus groups. These efforts are slated to conclude in early 2025. Afterward, the Assessment Team will present its findings to the Commission and workgroup co-chairs around February 2025.

The public health commission's assessment will provide data-driven insights, enabling targeted interventions that improve community health outcomes while reducing long-term healthcare costs through preventive measures and resource optimization. A complete timeline of the Commission's activities is detailed in appendix 5.3.

Develop a Listing of Preliminary Recommendations

Beginning in March 2025, the Commissioners and the workgroups will begin the process of integrating their findings and drafting initial recommendations. Based on the discussion and feedback, Commission support staff and workgroups will compile recommendations and final report sections.

Public Review and Input on Recommendation

The near final recommendation list will be published on the Commission website for public review and comment for at least 30 days. The Commission will use the public input process to finalize the recommendations and draft a final report. The report will include a response to any substantive public comments received on the draft recommendations.

The leadership will use its best efforts to come to a consensus on its recommendations. Any dissenting Commissioners can include their concerns in the final report.

Publish Final Report

Next fall, the Commission will present its final recommendations to the Governor, the Maryland General Assembly (including the Senate Budget and Taxation Committee, the Senate Finance Committee, the House Appropriations Committee, and the House Health and Government Operations Committee) in addition to the required parties prescribed by Maryland Statute § 2–1257 of the State Government Article.[xvii] The Commission will be ready to contribute to a dissemination process to acknowledge the contributions of Marylanders and their understanding of the recommendations. The final report will be released and distributed online no later than October 1, 2025.

5. Appendices

5.1 Commission Membership

The below roster represented people who are currently part of the Commission as of the publication of this report. We would like to thank everyone who has contributed, including past participants who are no longer engaged.

5.2 Commission on Public Health Appointed Membership

Co-Chairs

Meenakshi Brewster, MD, MPH, FAAFP Health Officer St. Mary's County Health Department	**Boris Lushniak, MD, MPH** Dean and Professor University of Maryland School of Public Health	**Oluwatosin Olateju, DrPH, MSN-CPHN, RN** Assistant Professor of Nursing Coppin State University; Adjunct Professor, Morgan State University School of Community Health and Policy

Commissioners

Hon. Heather Bagnall Delegate District 33C - Anne Arundel County	**Camille Blake Fall, JD** Director, Office of Minority Health and Health Disparities	**Christopher Brandt, MBA** Managing Director Audacious Capital
Jean Drummond, MPA President and CEO HCD International	**Nilesh Kalyanaraman, MD, FACP** Deputy Secretary of Public Health Services Maryland Department of Health	**Hon. Clarence Lam, MD, MPH** Senator District 12 - Anne Arundel and Howard Counties
Matthew Levy, MD, MPH, FAAP Health Officer Prince George's County Health Department	**Alyssa Lord, MA, MSc** Deputy Secretary for Behavioral Health Maryland Department of Health	**Fran Philips, RN, MHA** Former MDH Deputy Secretary of Public Health Services Former Anne Arundel County Health Officer
Nicole Rochester, MD Founder & CEO Your GPS Doc, LLC	**Maura Rossman, MD** Health Officer Howard County Health Department	**Michelle Spencer, MS** Practice Professor Deputy Director, Bloomberg American Health Initiative Johns Hopkins Bloomberg School of Public Health
Alen Twigg, LCPC, MBA Executive Director Behavioral & Community Health Brook Lane		

Commission Support Team

Hawi Bekele Bengessa, MHA Communications Student Intern University of Maryland School of Public Health	**Sarah Borah, MPH** Commission & Workgroup Staff Support Project Manager CDC Foundation	**Chidubem Egboluche, DVM, MPH** Commission & Workgroup Staff Support Morgan CARES Graduate Research Assistant Doctor of Public Health Student Morgan State University
Tiffany Gamble-Sanchez Student Intern Morgan State University	**Shane Hatchett, MS** Senior Advisor & Commission Manager CDC Foundation and St. Mary's County Health Dept.	**Dushanka Kleinman, DDS, MScD** Technical Advisor Professor Emerita University of Maryland School of Public Health
Michelle Kong, BA Commission & Workgroup Staff Support Assistant to the Dean University of Maryland School of Public Health	**Kristine Lawrance** Technical Writer Lawrance Policy Consulting	**Yonathan Mesfun** Meeting Support Intern Master of Public Health Student University of Maryland School of Public Health
Meghan Roney, MPH Commission & Workgroup Staff Support Director of Strategic Imperatives CDC Foundation		

Assessment Team

Amelia Arria, PhD Professor, Director, and Associate Dean for Strategic Initiatives University of Maryland School of Public Health	**Brittany A. Bugbee, MPH** Senior Strategic Analyst, Office of Strategic Initiatives (OSI) Senior Project Director, Center on Young Adult Health and Development (CYAHD) University of Maryland School of Public Health	**Anita Hakins, PhD** Co-Director Center for Urban Health Equity Morgan State University
Malinda Kennedy, ScD Project Director, The Maryland Collaborative Center on Young Adult Health and Development University of Maryland School of Public Health	**Grace McManus** Faculty Specialist, Center on Young Adult Health and Development University of Maryland School of Public Health	

Organizational Structure of the Commission

Communication and Public Engagement Workgroup

(= Appointed Member of Commission on Public Health)*

Co-Chairs

Tonii Gedin, RN, DNP Health Officer Anne Arundel County Health Department	**Sylvette La Touche-Howard, PhD, NCC, CHES** Assistant Dean, Office of Public Health Practice and Community Engagement Associate Clinical Professor University of Maryland School of Public Health

Workgroup Members

Diana Abney, MD Health Officer Charles County Health Department	**Cynthia Baur, PhD** Director, Horowitz Center for Health Literacy University of Maryland School of Public Health	**Ashley Bennett, LBSW, MHA, CCM** Local Health Improvement Plan Program Manager Coalition for a Healthier Frederick County
Camille Blake Fall, JD* Director, Office of Minority Health and Health Disparities Maryland Department of Health	**Rosalie Bright, ScD, MS** Volunteer Epidemiologist COVID Safe Maryland	**Stacy Cary-Thompson, MD** Pediatrician Cary Cares Parenting LLC
Saniya Chaudhry, PharmD Pharmacist	**Chase Cook** Director of Communications Maryland Department of Health	**Susanna Cooper, MPH** Health Communications Consultant IQ Solutions
Kasenia Coulson, MPH Tobacco Control Coordinator St. Mary's County Health Department	**Kisha Davis, MD, MPH** Health Officer Montgomery County Dept. of Health & Human Svcs.	**Jonathan Dayton, DrPH(c), MS, NREMT, CNE** Executive Director Maryland Rural Health Association
Jennifer Dixon Cravens, MS Faculty University of Maryland	**Jean Drummond, MPA*** President and CEO HCD International	**Amy Ford, BA, MLIS** Branch Manager St. Mary's County Library
Negin Fouladi, PhD, MPH, MS Assoc. Clinical Professor & Director of Online Graduate Studies Chair, Universitas21 Health Research Exchange University of Maryland School of Public Health	**Heather Gibson, BS, RCMC** Senior Healthcare Consultant RS&F (Rosen, Sapperstein & Friedlander, LLC)	**Susan Giordano, RN, BSN, MBA, FACHE, NEBC** Chief Nurse Executive Kaiser Permanente Mid-Atlantic Region
Amy Gyau-Moyer, MS, MBA Senior Director, Community Health University of Maryland Medical System	**Maggie Kunz, MPH** Health Planner Carroll County Health Department	**Laurie Lancaster, BSN** School Nurse St. Mary's County Public Schools
Lauren Levy, JD, MPH Health Officer Cecil County Health Department	**Jennifer Loring, MEd** Assistant Regional Director Maryland Department of Juvenile Services	**Chidalu Mbonu, MPH** Doctoral (DrPH) Student Loma Linda University School of Public Health
Nicole Morris, MSN, RN Director Mid Shore Health Improvement Coalition	**Paulani Mui, MPH** Assoc. Director, Office of Pub. Health Practice & Training Assistant Practice Professor Johns Hopkins Bloomberg School of Public Health	**Alicia Nelson, RN, MHA** Director of Nursing Division Director, Clinical Services St. Mary's County Health Department
Oluwatosin Olateju, DrPH, MSN-CPHN, RN* Assistant Professor of Nursing Coppin State University	**Michelle Rhodes, MHS, RN** CEO The Color of Wellness Media	**Nicole Rochester, MD*** Founder & CEO Your GPS Doc, LLC
Earl Stoner, MPH Health Officer Washington County Health Department	**Denise Thomas** Realtor Home Towne Real Estate	**Sara Whaley, MPH, MSW, MA** Senior Research Associate Johns Hopkins Bloomberg School of Public Health

Workgroup Support Team

Sarah Borah, MPH Workgroup Coordinator Project Manager, CDC Foundation	**Agnes Bernadine, BA** Workgroup Student Intern Master of Public Health Student University of Maryland School of Public Health	**Chidubem Egboluche, DVM, MPH** Commission & Workgroup Staff Support Morgan CARES Graduate Research Assistant DrPH Student, Morgan State University
Selma Osman, BA Workgroup Student Intern Master of Health Administration Student University of Maryland School of Public Health		

Data and Information Technology Workgroup

(= Appointed Member of Commission on Public Health)*

Co-Chairs

Matthew Levy, MD, MPH, FAAP* Health Officer Prince George's County Health Department	**Vacant**

Workgroup Members

Craig Behm, MBA CEO Chesapeake Regional Information System for Our Patients, Inc. (CRISP)	**Hassanatu Blake, PhD, MPH, MBA** Director, Health Equity and Social Justice National Association of County and City Health Officials (NACCHO)	**Christopher Brandt, MBA*** Managing Director Audacious Capital
Janet Brown, MSc Senior Research and Evaluation Specialist National Association of County and City Health Officials	**Robin Cahall, BHS, CPH** Health Officer Caroline County Health Department	**Myles Davenport, MPH** Epidemiologist, DC Office of the Chief Medical Examiner Cofounder/President, Brothers in Public Health Inc.
Morad Elmi, MBA Cofounder, Chief Strategy Officer Scene Health (formerly emocha Health)	**Christina Gray, MS** Epidemiologist Wicomico County Health Department	**Stephanie Harper, MD, MPP** Deputy Health Officer St. Mary's County Health Department
Alyssa Lord, MA, MSc* Deputy Secretary for Behavioral Health Maryland Department of Health	**Chris Nickerson, BSBA** CEO WellCheck, LLC	**Donna Perkins, MPH** Director of Assessment and Planning Anne Arundel Department of Health
Marcia Pearlowitz, MA Data Modernization Director Maryland Department of Health	**Marie Thoma, PhD** Associate Professor University of Maryland School of Public Health	**Xuanzi Qin, PhD, MSPH** Assistant Professor University of Maryland School of Public Health
William Webb, MS Health Officer Kent County Health Department		

Workgroup Support Team

Sarah Borah, MPH Workgroup Coordinator Project Manager, CDC Foundation	**Maryam A Hashmi, BA** Workgroup Student Intern MPH Student, University of Maryland School of Public Health

Funding Workgroup

(= Appointed Member of Commission on Public Health)*

Co-Chairs

Roger Harrell, MHA Health Officer Dorchester County Health Department	**Laurence Polsky, MD, MPH** Physician Calvert County Health Department

Workgroup Members

Sarah Clarke, MBA, CMPE Partner, Healthcare Division RS&F (Rosen, Sapperstein & Friedlander, LLC)	**David Davis, BA** Budget and Finance Director Public Health Services Administration Maryland Department of Health	**Eryn Greaney, MPA** Immunization, Project Manager National Association of County and City Health Officials
Sonia Gupta, MPH, MBA Founder/CEO Women's Health Technologies	**Jennifer Hare, CPA** Acting Health Officer Garrett County Health Department	**Karine Ireland** Acting Health Officer Talbot County Health Department
Rebecca Jones, RN, BSN, MSN Health Officer Worcester County Health Department	**Ruth Maiorana, BS** Executive Director Maryland Association of County Health Officers	**Sadiya Muqueeth, DrPH, MPH** Chief Health Policy Officer, Baltimore City Health Department; Assistant Scientist, Johns Hopkins Bloomberg School of Public Health
Gena Spear, BS Health Officer Allegany County Health Department	**Allen Twigg, LCPC, MBA*** Executive Director, Behavioral & Community Health Brook Lane	

Workgroup Support Team

Sarah Borah, MPH Workgroup Coordinator Project Manager, CDC Foundation	**Duncan MacGowan Coltharp, BA** Workgroup Student Intern University of Maryland School of Public Health	**Shinel Mullings, BA** Workgroup Student Intern MPH Student, University of Maryland School of Public Health

Governance and Organizational Capabilities Workgroup

(= Appointed Member of Commission on Public Health)*

Co-Chairs

Barbara Brookmyer, MD, MPH Health Officer Frederick County Health Department	**Fran Philips, RN, MHA*** Former MDH Deputy Secretary of Public Health Services Former Anne Arundel County Health Officer

Workgroup Members

Meenakshi Brewster, MD, MPH, FAAFP* Health Officer St. Mary's County Health Department	**Angela Cochran, MS** Division Director, Health Promotion & Community Services St. Mary's County Health Department	**Erica Drohan, CFA** CFO Scene Health
Marie Flake, MPH, BSN Senior Program Manager in Workforce Development The Public Health Foundation	**Joan Gelrud, MSN, CPHQ, FACHE** Commissioner Maryland Healthcare Commission	**Isis Gomes, MPA** MPH Candidate Johns Hopkins Bloomberg School of Public Health

Kathleen Hoke, JD Professor Director, Legal Resource Center for Public Health Policy University of Maryland Carey School of Law	**Nilesh Kalyanaraman, MD, FACP*** Deputy Secretary of Public Health Services Maryland Department of Health	**Maria Maguire, MD, MPP, FAAP** Medical Director CareFirst BlueCross BlueShield
Matthew McConaughey, MPH Health Officer Wicomo County Health Department	**Maura Rossman, MD*** Health Officer Howard County Health Department	**Michelle Spencer, MS*** Practice Professor Deputy Director, Bloomberg American Health Initiative Johns Hopkins Bloomberg School of Public Health
Lucy Wilson, MD, MPH Health Officer Baltimore County Health Department	**Wendy Wolff, MPH** Director of Strategic Engagement Maryland Nonprofits	

Workgroup Support Team

Hawi Bekele Bengessa, BA Workgroup Student Intern MHA Student, University of Maryland School of Public Health	**Sarah Borah, MPH** Workgroup Support CDC Foundation	**Shane Hatchett, MS** Workgroup Coordinator CDC Foundation & St. Mary's County Health Department

Workforce Workgroup

(= Appointed Member of Commission on Public Health)*

Co-Chairs

Brian Castrucci, DrPH, MA President and CEO de Beaumont Foundation	**Susan Doyle, RN** Health Officer Carroll County, Maryland

Workgroup Members

Sanmi Areola, PhD Deputy Chief Administrative Officer for HHS & Education Prince George's County	**Marcy Austin, BA** Health Officer Harford County Health Department	**Hon. Heather Bagnall*** Delegate District 33C - Anne Arundel County
Lawrence Baird, MBA Founder/Consultant Baird Consulting Group	**Shawn Cain, BA** Deputy Health Officer Anne Arundel County Health Department	**Julie Campbell, MBA** Director of Human Resources Talbot County Health Department
Joseph Ciotola, Jr., MD Health Officer Queen Anne's County, Maryland	**Amber D'Souza, PhD** Professor Johns Hopkins Bloomberg School of Public Health	**Shannon Edward, MA** Experiential Learning Manager, Faculty University of Maryland School of Public Health
Deya Greer, MAT Lead Analyst for Workforce & Leadership Development National Association of County & City Health Officials (NACCHO)	**Mary Beth Haller, JD** Interim Commissioner of Health Baltimore City Health Department	**Vanessa Lamers, MPH, MESc** Workforce Development Director, Public Health Services Administration Maryland Department of Health
Lisa Laschalt, MPH, BA, REHS/RS, LEHS Environmental Health Director Charles County Department of Health	**Boris Lushniak, MD, MPH*** Dean and Professor University of Maryland School of Public Health	**Ilise D. Marrazzo, MPH, BSN, RN** Director of Nursing Director, Bureau of Family Health Services Howard County Health Department
Mona Mittal, PhD Associate Professor University of Maryland School of Public Health	**Katie Nelson, PhD, MSN, RN** Assistant Scientist Johns Hopkins Center for Indigenous Health	**Ahmad Ozair, MD** Sommer Scholar Johns Hopkins Bloomberg School of Public Health

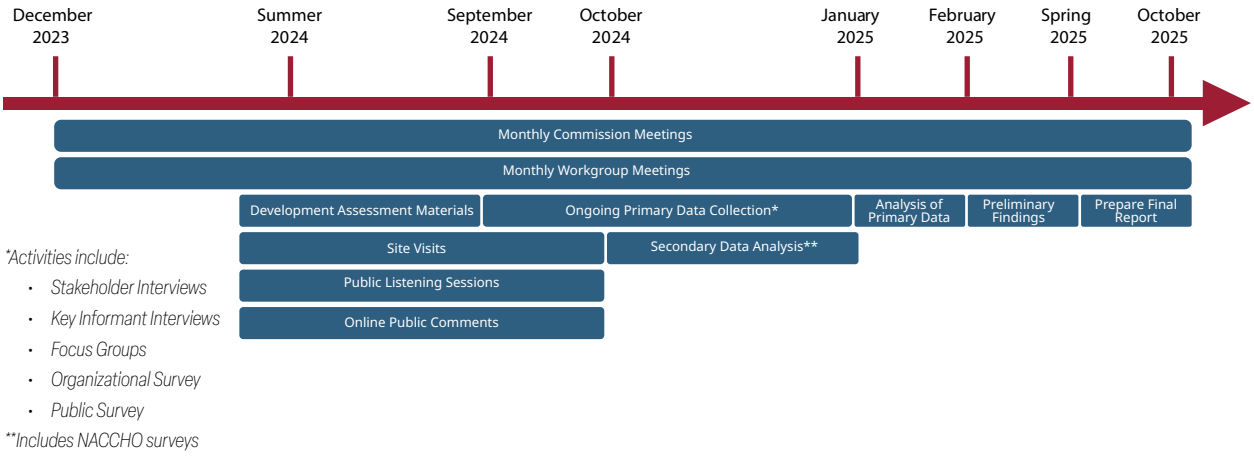
Beth Resnick, DrPH, MPH Assistant Dean for Public Health Practice Johns Hopkins Bloomberg School of Public Health	**Michael Rhein, MPA** President & CEO Institute for Public Health Innovation	**Elvis Safary, PhD** Scientist and Project Lead FIND
Danielle Weber, MS, RN Health Officer Somerset County Health Department	**Randi Woods, MS, MBA, RN** CEO STAR Community Health Solutions	**Tracy Zeeger, MPH, PhD** Asst. Dean of Public Health Practice and Comm. Eng. Director of Undergraduate Studies, Clinical Associate Professor Univ of Maryland School of Public Health

Workgroup Support Team

Michelle Kong, BA Workgroup Staff Support Assistant to the Dean University of Maryland School of Public Health	**Bethany Kuerten, MSc-GH** Workgroup Staff Support Senior Program Associate de Beaumont Foundation	**Chamodi Jayasiri, BA** Workgroup Student Intern Master of Public Health Student University of Maryland School of Public Health

5.3 Timeline

Key Activities by Month



**Activities include:*

- *Stakeholder Interviews*
- *Key Informant Interviews*
- *Focus Groups*
- *Organizational Survey*
- *Public Survey*

***Includes NACCHO surveys*

Figure 9

5.4 Acronyms as They Appear in the Report

Acronym	Spelled Out
The Commission	**Commission on Public Health**
MDH	**Maryland Department of Health**
LHD	**Local Health Department**
LHO	**Local Health Officer**
BOH	**Board of Health**
HHS	**Health and Human Services**

Acronym	Spelled Out
MDE	Maryland Department of the Environment
CDC	Centers for Disease Prevention and Control
PHAB	Public Health Accredidation Board
FPHS	Foundational Public Health Services
FPHC	Foundational Public Health Capabilities
FPHA	Foundational Public Health Areas
CMS	Centers for Medicare and Medicaid Services
HSCRC	Health Services Cost Review Commission
AHEAD	Advancing All-Payer Equity Approaches and Development
FPH	Foundational Public Health
MACHO	Maryland Association of County Health Officers
PIO	Public Information Officer
NACCHO	National Association of County and City Health Officials
MHA	Maryland Hospital Association
PHWINS	Public Health Workforce Interests and Needs Survey
IT	Information Technology
FQHC	Federally Qualified Health Centers

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