MARYLAND
COMMISSION
ON PUBLIC HEALTH

Building the Future of Maryland Public Health

2025 FINAL REPORT

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LETTER TO THE GOVERNOR AND GENERAL ASSEMBLY

October 1, 2025

The Hon. Wes Moore
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401

The Hon. Bill Ferguson
President of the Senate
Maryland Senate
100 State Circle
Annapolis, MD 21401

The Hon. Adrienne A. Jones
Speaker of the House
Maryland House of Delegates
100 State Circle
Annapolis, MD 21401

Re: Health General Article § 13-5107 (MSAR # 15641)

On behalf of the Maryland Commission on Public Health, we are honored to present the Commission's final report as required by House Bill 1333 (2024) in compliance with Section 2-1257 of the State Government Article of the Annotated Code of Maryland. This report reflects the Commission's ongoing commitment to reimagining and strengthening public health across our state, with a particular focus on achieving health equity for all Marylanders.

The Maryland Commission on Public Health acknowledges that this report comes at a time of significant changes to the public health and healthcare landscape across the country. These developments have contributed to public uncertainty, underscoring the importance of strong state and local public health systems. As federal coordination shifts, state and local public health agencies, academic institutions, and professional organizations are increasingly taking the lead in advancing evidence-based health initiatives, maintaining essential data systems, and addressing health coverage for vulnerable populations.

The Commission's assessment of Maryland's public health infrastructure provides a well-timed comprehensive review of foundational public health capabilities in our state, serving as a valuable baseline for future progress. It complements the efforts of the Maryland Department of Health's recently updated State Health Assessment and State Health Improvement Plan. These documents and our workgroups' thoughtful research helped inform the Commission's review of the state and local public health system. The resulting recommendations offer a clear path forward to improving population health and ensuring all Marylanders have the best chance at achieving well-being.

Our state's strong public health expertise and established infrastructure, with thoughtful implementation through community engagement, can foster a healthier workforce and create the conditions for sustained economic prosperity. We firmly believe this coordinated effort helps demonstrate that health truly is wealth.

Sincerely,

Meena Brewster, MD, MPH, FAAFP Boris Lushniak, MD, MPH Oluwatosin Olateju, DrPH, MSN-CPHN, BSN, RN

CC: Senate Budget and Taxation Committee, Senate Finance Committee
House Appropriations Committee, House Health and Government Operations Committee
Secretary of Health, Maryland Department of Health

COMMISSIONERS' REMARKS ON THE IMPORTANCE OF THIS WORK

Through strengthened infrastructure, strategic alignment of resources, and expanded partnerships, this Commission has advanced recommendations that lay the foundation for a more resilient public health system—one equipped to serve all Maryland communities today and for generations to come.
—Allen Twigg, Commissioner

The Commission on Public Health conducted a thoughtful process of engaging communities across Maryland through site visits, listening sessions, and written responses. The Department appreciates hearing from a wide range of voices and experts from across the state and looks forward to continuing our work with partners to protect and advance the health and well-being of all Marylanders.
—Maryland Department of Health Ex Officio Commissioners

The Maryland Commission on Public Health has laid a foundation for a stronger, more equitable, and more resilient public health system. This report reflects the dedication of commissioners, workgroup members, partners, and community voices, and we are deeply grateful to the Governor, the Maryland General Assembly, and all stakeholders whose support made this work possible. Our recommendations are a call to action—one that can shape a healthier, more prosperous future for Maryland and serve as a model for the nation. The work begins now.
—Dr. Oluwatosin Olateju, Commissioner

As with so many important efforts, this plan took a village—and I am so grateful to the team that worked so hard and so generously on behalf of all Marylanders. We came together for two years to create a path to meaningful improvement in the health of our communities and our great state. Now, with the completion of this public health roadmap, we arrive at the crucial beginning: Serving the people of our state to propel public health in Maryland fearlessly forward! I have no doubt that, thanks to the efforts of this village, we are ready to be a national leader in advancing better health for all.
—Dr. Boris Lushniak, Commissioner

The work of the Public Health Commission was tremendously powerful in shedding light on the core of public health practice in our great state and redefining how we work together to become a healthier Maryland. I am grateful for the opportunity to be a part of such an historic process. This report however, is only as good as the commitment of our public officials to funding and implementing these strategies, which will push Maryland to the front of the curve in changing health.
—Dr. Matthew Levy, Commissioner

It has been an honor representing local health department's on the Maryland Commission on Public Health. The Final Report from the Commission is a critical step forward for local health departments. It recognizes the essential role we play on the front lines and provides the tools and vision we need to build a more responsive, equitable, and sustainable public health infrastructure across the state.
—Dr. Maura J. Rossman, Commissioner

This report and the thoughtful recommendations within reflect a thorough, inclusive, and transparent process of assessing Maryland's public health system and identifying meaningful opportunities for improvement. Unified by a mission to advance the health and well-being of all Marylanders, numerous individuals and organizations - across both public and private sectors - devoted extraordinary time, resources, and expertise to the Commission's work. The result is a bold and transformative blueprint for the future - one that reaffirms the vital role of a robust public health system shaping a healthier Maryland.
—Dr. Meena Brewster, Commissioner

By investing in the people, infrastructure, and systems that support public health, we are ensuring healthier communities today and a stronger state for generations to come. These evidence-based recommendations lay the groundwork for a modern, resilient public health system that every person living in Maryland deserves. These recommendations are a roadmap to strengthen Maryland's communities, reduce disparities, and make sure every resident has the best chance to thrive. Investing in prevention and public health infrastructure is one of the smartest choices we can make as a state.
—Michelle Spencer, Commissioner

Being part of the Maryland Commission on Public Health has been a great honor and privilege. Over the last two years we have learned, deliberated, discussed, and collaborated as we've worked diligently to provide a comprehensive roadmap for a transformative, equitable, comprehensive, impactful public health system in our great state of Maryland. I am proud of this work and grateful for all who contributed and for those who now have the arduous task of bringing the recommendations to fruition.
—Dr. Nicole Rochester, Commissioner

In this time when public health faces unprecedented challenges, I am deeply appreciative of all the members of the Commission who stepped up and contributed countless hours and enormous effort towards improving our state's public health system. This report gives the state a clear roadmap towards modernizing our public health system and improving the health of all Marylanders for many years to come.
—Sen. Clarence Lam, Commissioner

ACKNOWLEDGEMENTS

Support for this work was provided by the CDC Foundation through grants from Bloomberg Philanthropies, Kaiser Permanente, the Kaiser Permanente Fund at East Bay Community Foundation, the Kresge Foundation and the Robert Wood Johnson Foundation. The viewpoints and recommendations included in this report do not necessarily represent the positions of the CDC Foundation or the other funders.

The Commission extends its sincerest thanks to its academic partners at the Morgan State University School of Community Health and Policy and the University of Maryland School of Public Health for their comprehensive assessment of our state and local public health system. Their rigorous research, thoughtful engagement with stakeholders, and insightful analysis provided invaluable findings that have significantly informed and shaped the recommendations in this final report. The academic team's final report can be accessed on the Commission webpage and maintained in the Maryland State Archives.[2]

TABLE 1: ENTITIES SUPPORTING THE EFFORTS OF THE COMMISSION

Project Partners	Role
The Commission	Assess the foundational public health capabilities of state and local health departments and analyze the state's ability to respond to major public health challenges
Commission Co-Chairs	Leadership of the Commission
Workgroup Members	Provide expertise to inform the direction of the Commission, assessment, etc.
Workgroup Co-Chairs	Leadership of the workgroups
Maryland Department of Health (MDH)	Advisory role
Maryland Rural Health Association	Promoting and disseminating the Public Health Survey
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, workgroup support and staffing, contractor support, project management support
de Beaumont Foundation	Workgroup support and staffing, assessment support
Morgan State University, School of Community Health and Policy	Assessment and Commission support, workgroup support
University of Maryland, College Park, School of Public Health	Assessment and Commission support, advising, workgroup support
Johns Hopkins University Bloomberg School of Public Health	Staff support
Coppin State University	Assessment and Commission support, Commission branding, workgroup support
Shane Hatchett, Advent Solutions, LLC	Commission management, workgroup support
Baltimore County Department of Health	Hosting Commission meetings
Prince George's County Health Department	Hosting Commission meetings
Horowitz Center for Health Literacy	Assessment support

Executive Summary

INTRODUCTION

Through collaborative learning and listening, inclusive decision making, and strategic recommendations, the Maryland Commission on Public Health (the Commission) lays the groundwork for the State of Maryland to create sustainable improvements to our public health system—benefitting everyone who lives, learns, and works in our state.

The time has never been more urgent for a call to action to recognize public health as a fundamental driver of social and economic productivity.

The health and well-being of our society is our most valuable asset; it is essential to a strong, economically and socially thriving community. Technological advancements, the rise of chronic diseases, and the disproportionate impact of health crises on underserved populations, as well as lessons learned from the COVID-19 pandemic and other emerging infectious diseases such as measles, Influenza A (H5N1), Mpox, and Ebola, among others, highlight an urgency for reimagining, strengthening, and modernizing the public health infrastructure.

Commission Charge and Composition

The 16-member Commission was established in 2023 as an advisory body whose purpose was "to make recommendations to improve the delivery of foundational public health services in the State" by evaluating the state's foundational public health capabilities. The end goal was to formulate strategic, actionable recommendations to improve statewide and local public health services and capabilities that build upon existing strengths and address gaps and modernize and enhance the public health system.

The Commission is composed of state health officials, local health officers, academic partners, thought leaders, and legislators. The Maryland Department of Health (MDH) is represented by officials from the Public Health Services Administration, the Behavioral Health Administration, and the Office of Minority Health and Health Disparities. Several leaders and professionals across public and private sectors have also contributed through the Commission's five workgroups, which include:

- Communications and Public Engagement
- Data and Information Technology
- Funding
- Governance and Organizational Capabilities
- Workforce

> **"The time has never been more urgent for a call to action to recognize public health as a fundamental driver of social and economic productivity."**

In addition to the topic areas covered by the workgroups, the Commission was charged with assessing other key areas, including the organization of MDH and local health departments (LHDs), procurement, contractor oversight, maternal mortality, and emergency response. The end goal was to formulate strategic, actionable recommendations to improve statewide and local public health services and capabilities that build upon existing strengths and address gaps.

Commission Key Activities

The Commission gathered detailed insights on Maryland's public health system from multiple viewpoints. It held monthly meetings with key stakeholders and the workgroups, led regional listening sessions, and solicited public comments to assess the Maryland public health system's challenges and opportunities.

In collaboration with the University of Maryland School of Public Health, Morgan State University School of Community Health and Policy, the de Beaumont Foundation, and Coppin State University, the Commission conducted a comprehensive system assessment. It began with a rigorous process to develop the assessment tools, including developing assessment questions, identifying stakeholders, and framing the strategy. The assessment methodology included interviews, focus groups, and surveys with a variety of public health leaders and individuals in Maryland who hold critical roles affecting the public health infrastructure. The goal was to assess Maryland's foundational public health capabilities and its ability to respond to public health challenges.

The Commission developed an interim report[3] that provided an in-depth review of the Commission's activities throughout 2023 and 2024, an overview of the five workgroups and its early findings, identification of emerging issues, and an overview showing how the recommendations would be formed.

SUMMARY OF FINDINGS

The findings of the Commission, detailed in this report, reveal the collective strength of Maryland's diverse communities while also highlighting the ways we can do better.

The five Commission workgroups operated with a common understanding that key elements of effective governmental public health operations require clear governance and organizational structures; a skilled, multidisciplinary, diverse, and prepared workforce with a stable pipeline plan; timely data and information technology availability and resources; sufficient funding through state and local governmental funds and external funds; clear communication and sustainable public and community engagement; and partnerships. The Commission identified the following overarching needs:

Need for Strengthening Governance, Supporting Leadership, and Improving Internal Administrative and Communication Operations

The core of public health activities is centered in the governmental portion of the public health system, which comprises MDH and 24 LHDs. Operational and capability challenges exist as well as the need to clarify responsibilities, improve communication within and beyond governmental public health, and expand accreditation.

Need to Enhance our Information Technology Capabilities

Data, information technology systems, and epidemiologic expertise are critical components for designing, operating, and evaluating public health programs in Maryland. There is a need to build better systems to support data-driven decision-making and business operations, and to improve data access, collection, management, analysis, and utilization. Additional identified needs include tracking service delivery to understand the number of individuals who received different services, improving interoperability of the current information technology infrastructure, and implementing an electronic health record system designed specifically for public health.

Need to Build a Stronger Human Resources System to Support the Public Health Workforce

A strong public health infrastructure in Maryland must have a large, diverse workforce with skills and expertise in a wide variety of disciplines. Maintaining a responsive workforce requires effective recruitment and retention, strategic personnel training and career development, and assignment flexibility. Workforce shortages are pervasive and individuals with particular skillsets are in high demand. Recruitment can be difficult due to administrative hiring impediments, limitations of current job classifications, non-competitive salaries, and limited incentives and professional development. Investments must be made to address the needs of the current workforce and develop the future public health workforce.

Need to Expand Funding and Examine Funding Models

Concerns regarding funding for public health were widely expressed. There is a need to examine the current core funding model, explore and expand sources of funding, and enhance the capacity for procurement and administrative fiscal operations.

Need to Bolster Communication with the Public

Clear communication and public health engagement are core competencies of public health practice and even more critical in this time of mistrust in public health. Key challenges include the need to broaden public engagement and invest in regular dialogue that is provided in ways and places that are acceptable and accessible, including the expansion of language access. Limitations in staff with communications and health literacy expertise, as well as limited support to enhance the use of communication methods and the evaluation of communication strategies, are additional challenges.

Need to Leverage and Strengthen Relationships with Partners

Public and private state and local partners—state government agencies, community partners, healthcare organizations, health professions, academic organizations, and the business sector—play a critical role in supporting and enabling both MDH and LHDs to deliver foundational public health services. There is a need to maintain and strengthen partnerships, and Maryland's public health system partners want to be more helpful and increase their collaborations.

Need to Be More Prepared and Proactive

There is a need to be more prepared and more prevention-oriented in our thinking, our actions, and our policies. We must shift gears from reactive to proactive public health strategies that focus on prevention and primary care.

This report describes many lessons learned from the COVID-19 pandemic, along with a discussion of how our public health infrastructure directly impacts our ability to address urgent issues such as maternal and infant mortality, management of behavioral health conditions, and overdoses. These discussions re-emphasized the importance of ensuring support for public health capabilities.

Working to Ensure Health for All

Maryland's diverse public health, regional and county-specific needs, and rapidly growing population variation require flexibility when considering approaches and human, fiscal, and technological resources. 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 socioeconomic and racial lines. Health disparities are clear and unquestionable. Health equity work at the state and local levels is valued and takes place through both formal and informal mechanisms.

RECOMMENDATIONS

The Commission's work has culminated in a set of recommendations—proposed actions that, if implemented, would strengthen and improve the delivery of foundational public health services in the state—based on the findings from each of the five workgroups and assessment activities.

The recommendations address five major themes that summarize key focus areas for action. Each theme includes strategic objectives, with targeted actionable recommendations. Theme 1 and Theme 2 focus on improving Maryland's governmental public health, while Themes 3, 4, and 5 are aimed at enhancing Maryland's public health system. This organizational framework aims to highlight the interconnection of recommendations across themes and assist in implementation of actions to improve public health.

The themes, strategic objectives, and recommendation titles are listed below. Additional narrative and the entirety of the recommendations are described in The Commission Recommendations section of the report.

1. Strengthen Public Health Infrastructure

Leadership and Governance

- ▸ **Realize Benefits of Maryland's Governance Structure**
  - Shared Governance Support
  - Co-Creation Framework Model

- **Align Governmental Public Health Activities**
  - Set of Shared Health Outcome Metrics
  - Public Health Foundational and Behavioral Health Services
  - State Public Health Volunteer Coordinator
  - Maryland Responds Medical Reserve Corps Expansion
  - Environmental Health System
- **Create Equity Impact Assessment Policies**
  - Equity Impact Assessment Policy For Executive Branch
  - Equity Impact Assessment Policy For General Assembly
- **Enhance Internal Communications**
  - Maryland Department of Health (MDH) Public Health Grand Rounds Series
  - Local Health Department (LHD) Accreditation
  - Listserv For LHDs

Human Resources

- **Upgrade The Human Resource System**
  - State Personnel System Task Force Recommendations
  - Access To Complete State Personnel Job Classifications
  - Distinct MDH/LHD Job Classification Options
  - Study/Commission on Public Health Human Resources Reform
- **Protect The Existing Workforce**
  - Legal Protection of Public Health Employees
  - Statewide Chief Nursing Officer
- **Establish Innovative Teams**
  - Bureau Of LHD Assistance and Support
  - Grant Management MDH Team
  - Public Health Resource Team

Funding

- **Review Existing Funding Mechanisms**
  - Core Funding Model Assessment
  - Procurement And Contracting Efficiencies
  - Grant Flexibility
- **Explore New Funding Models**
  - Medicaid Reimbursement Taskforce
  - Reinvest Healthcare Savings
  - Charitable Foundations

- **Dedicate New Funding To These Critical Areas: *Health Communication, Technology, and Health Needs Assessments***
  - Health Communications Development and Dissemination
  - Information Technology
  - Community Health Needs Assessment Support For LHDs

2. Modernize and Maximize Communication, Data, and Information Technology Tools

- **Bolster Public Engagement**
  - Visibility of Public Health
  - Public Feedback
  - Central Community Portal

- **Activate Health-Related Communication**
  - LHD Public Information Officer's Leadership
  - Language Access Support
  - Plain Language Information Support
  - Health Communications Tools Modernization

- **Streamline Information Technology (IT) Operations**
  - Commission on Data and Information Systems Modernization
  - Five Year Enterprise Data and IT System Plan
  - Efficiency of Business Functions
  - Public Health Record Digitalization

- **Enhance Health-Related Data Collection, Management, and Analysis Capabilities**
  - Centralized Data Repository
  - State Electronic Health Record System
  - Uniform Data Standards
  - Hub and Spoke Analytic Model
  - Data Use Efficiency
  - Laboratory System Assessment

3. Leverage and Formalize Partnerships

- **Coordinate with Governmental Agencies**
  - Social Service, Aging, Housing, and Transportation Collaboration

- **Partner with Academic Institutions**
  - Academic Health Department Partnerships

- **Heighten Partnerships with Statewide Non-Profit Health Organizations**
  - Maryland Association of County Health Officers (MACHO) Partnership
  - Community, Advocacy, and Professional Organizations
- **Strengthen Connections with Health Care Organizations**
  - Private Health Systems
- **Build Stronger Relationships with the Private Sector**
  - Public Health Business Advisory Board

4. Bridge Public Health and Health Care Service Delivery

- **Enhance Connections Between Public Health, Primary Care, and Health Care Delivery Systems**
  - Primary Care Workforce Support
  - Public Health and Primary Care Continuum
  - Public Health Navigators
- **Clarify Public Health Capacities for the Legislature and the Public**
  - Elected Official Onboarding

5. Pave the Way for Current and Future Public Health Leaders

- **Invest in Public Health Workforce Policy, Planning, and Professional Development**
  - Public Health Workforce Commission
  - Statewide Public Health Workforce Training Strategy
  - IT and Analytics Workforce
- **Design and Develop Innovative Educational and Experiential Offerings**
  - Maryland Corps to Public Health Careers
  - Youth Education Public Health Literacy

By acting on the recommendations, the State has an opportunity not only to enhance the health of Marylanders, but also to position Maryland as a national leader in multidisciplinary and innovative approaches to public health system improvement.

SECTION 1

What We Did

INTRODUCTION

The time has never been more urgent for a call to action to recognize public health as a fundamental driver of social and economic productivity. Maryland's leaders had the vision to establish the Maryland Commission on Public Health (the Commission) in June 2023 to understand the status of our public health infrastructure, how well the system is performing to promote and protect the health of all Marylanders, and our capacity to launch a coordinated and effective response to a widespread emergency.

Public health is what society does collectively to ensure the conditions that are needed for people to be healthy. The public health system in Maryland relies on a shared governance model, which involves shared responsibilities and resources between the state and local governments. This system gives local health departments (LHDs) significant operational autonomy while remaining part of the state's public health system, which makes implementation of programs and other strategies possible. This system is complex: leaders must work collaboratively within and across multiple governmental agencies as well as with healthcare and community organizations. Maryland's shared governance structure allows flexibility in tailoring and implementing strategies to manage health challenges most effectively at both the state and local levels.

The findings of the Commission, detailed in this report, reveal the collective strength of Maryland's diverse communities while also highlighting ways in which we can do better. It charts a path forward with specific, actionable, and bold recommendations. By acting on the recommendations, the state has an opportunity not only to enhance the health of Marylanders, but also to position the state as a national leader in multidisciplinary and innovative approaches to public health system improvement.

"The findings of the Commission reveal the collective strength of Maryland's diverse communities but also highlight ways in which we can do better. It charts a path forward with specific, actionable, and bold recommendations."

Current national conversations around public health focus on keeping our communities safe, ensuring access to fundamental health services, and distributing health information in a timely manner so local communities can proactively and effectively address the health and safety challenges of their residents. What is often left out of the conversation is an appreciation of how we all—not just those individuals receiving services—benefit from a smoothly functioning, well-resourced, and state-of-the-art public health infrastructure. Keeping people healthy, improving quality of life, and fostering community resilience reduces healthcare costs, strengthens the workforce, alleviates caregiver burden, and ultimately forms the foundation for a productive society.

COMMISSION, CHARGE, AND PROCESS

The Commission

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 threats, the Commission was charged with assessing the impact of Maryland's foundational public health capabilities and the public health infrastructure of state and local health departments, and with issuing a final report with recommendations to improve public health services. After two years of convening, learning from senior leaders, listening to community members, and assessing input from diverse stakeholders, the Commission, with input from its five workgroups, is making recommendations for reform in several areas. These areas include, but are not limited to, the organization of state and local health departments; information technology, information exchange, and data analytics; workforce; procurement; funding; and communication and public engagement.

Membership

Based on legislative requirements, the membership of the Commission consisted of:

- One state Senator
- One member of Maryland's House of Delegates
- The Maryland Department of Health (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 (HBCU)
- Three to five members of the public who have demonstrated interest in public health and experience in health equity, information technology, workforce, or population health

Furthermore, the Commission was to be co-chaired by one of the three local health officers, one of the two representatives from state academic institutions with expertise in public health systems, and a faculty member from a public health program at a historically Black college or university. Additionally, the two academic entities represented by the co-chairs were to be responsible for providing staff support to the Commission.

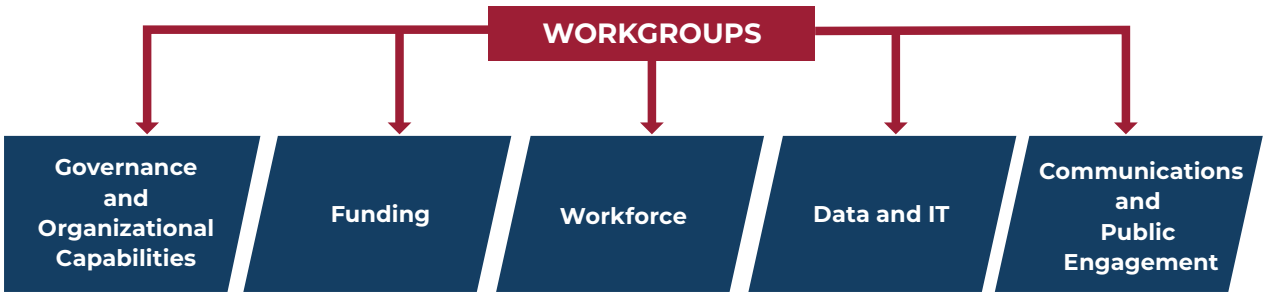
See Appendix 4 for the full list of current and former members.

Workgroups

The Commission's authorizing statute required the formation of five workgroups. The Commission incorporated the legislation's sixth topic area, procurement, which includes contractor oversight, into the charge of all five workgroups, instructing them to consider procurement in their recommendations.

These workgroups, which comprised more than 100 members from across Maryland with state, local, private, academic, and national subject matter expertise, helped inform the Commission on the legislated topics, supported assessment design, and developed topic-specific recommendations for the Commission's consideration. The workgroups included a broad array of members representing different disciplines; practices; public, private, and non-profit experiences; and geographic perspectives.

FIGURE 1. COMMISSION WORKGROUPS



The Charge

In accordance with House Bill 214, the Commission was tasked to review the current state of public health activities in Maryland and offer recommendations to accelerate progress toward a vision of a future where all Marylanders can achieve their full potential for lifelong health and well-being. The Commission's work was to consider the context of Maryland's relatively unique "largely shared" governance model, healthcare delivery system initiatives and opportunities, and health-related programs and contributions of other Maryland agencies and commissions. Commissioners were instructed to integrate health equity in all aspects of their work and focus on Maryland's diverse population characteristics, health and well-being needs, social determinants of health assets, and challenges.

Defining The Commission's Path for a Healthier Maryland

The Commission adopted the following vision, mission, and values statements at its meeting on February 20, 2025.

Vision

A healthy and thriving Maryland where every community flourishes with equitable access to comprehensive public health services, empowering everyone to achieve well-being and improved health outcomes.

Mission

Through collaborative learning and listening, inclusive decision-making, and strategic recommendations, the Commission helps create sustainable improvements to public health systems that benefit everyone who lives, learns, and works in our state.

Values

The values that influenced the Commission's decision-making and approach to this work are communication, equity, inclusion, and innovation.

- **Communication**: Open, transparent, clear, data-informed, and consistent communication fosters trust and collaboration. We strive to make its work accessible and understandable, ensuring that its messages resonate with and are relevant to all Marylanders.
- **Health equity**: We value the role that equity plays in public health. We believe that public health systems should lead with health equity values and acknowledge that communities are diminished when individuals are left behind.
- **Inclusion**: Diverse voices strengthen our efforts. We must prioritize representation from the breadth of Maryland's communities and demographics, ensuring that those we serve have a meaningful role in shaping and implementing health programs. We believe that inclusion must be reflected in governance through clear lines of authority that lead to effective policies and programs at state and local levels.
- **Innovation**: We embrace creative solutions and continuously seek out emerging, scientifically sound practices to enhance public health. By fostering a culture of innovation, we aim to position Maryland as a leader in effective and forward-thinking health strategies that achieve improved outcomes.

The Commission addressed its purpose with a three-pronged approach. The first prong of the approach was to **ASSESS**. The Commission assessed the state and local public health system through multiple quantitative and qualitative tools. Having completed its assessment phase, the Commission now presents this report to **ARTICULATE** the desired future for public health capabilities in Maryland and provide recommendations to improve the delivery of foundational public health services. The Commission will then use the report's publication to submit its findings to state and local leaders, as well as others in the public health system, to **ADVANCE** the recommendations.

The Process

The Commission approached its research and analysis of the state of public health in Maryland in various ways before making its recommendations.

1) **Commission meetings:** The Commission met 26 times since its first meeting in December 2023. It notified the public in advance of each meeting and invited the community to attend meetings in person or virtually. It recorded all meetings and posted them online on the Commission's website. The co-chairs, Dr. Meenakshi Brewster, Dr. Boris Lushniak, and Dr. Oluwatosin Olateju, arranged guest speakers at Commission meetings and guided the commissioners' discussions on the topics highlighted in the statute. A full list of speakers who presented to the Commission and its workgroups can be found in Appendix 3.
2) **Workgroup meetings:** The workgroup co-chairs convened their groups monthly to maintain member engagement and allow sufficient time to incorporate expert testimony, facilitate rich discussion, and generate well-crafted recommendations. Each workgroup had a charter and was 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. Workgroup co-chairs arranged for guest speakers at workgroup meetings; a full list of speakers who presented to the workgroups can be found in Appendix 3.

3) **Framework Development:** Knowing fully well that evidence-based public health is a fundamental concept for public health practice, the Commission decided to underpin its work in science. Moreover, greater attention to evidence-based approaches is warranted in public health. The Conceptual Model for the Maryland Commission on Public Health[4] was designed in February 2024 by Dr. Oluwatosin Olateju (Commission co-chair and academic partner representing Maryland HBCUs—Coppin State University and Morgan State School of Community Health and Policy), shared with Commission members in early February, and later presented at the Commission's general meeting on June 6, 2024.

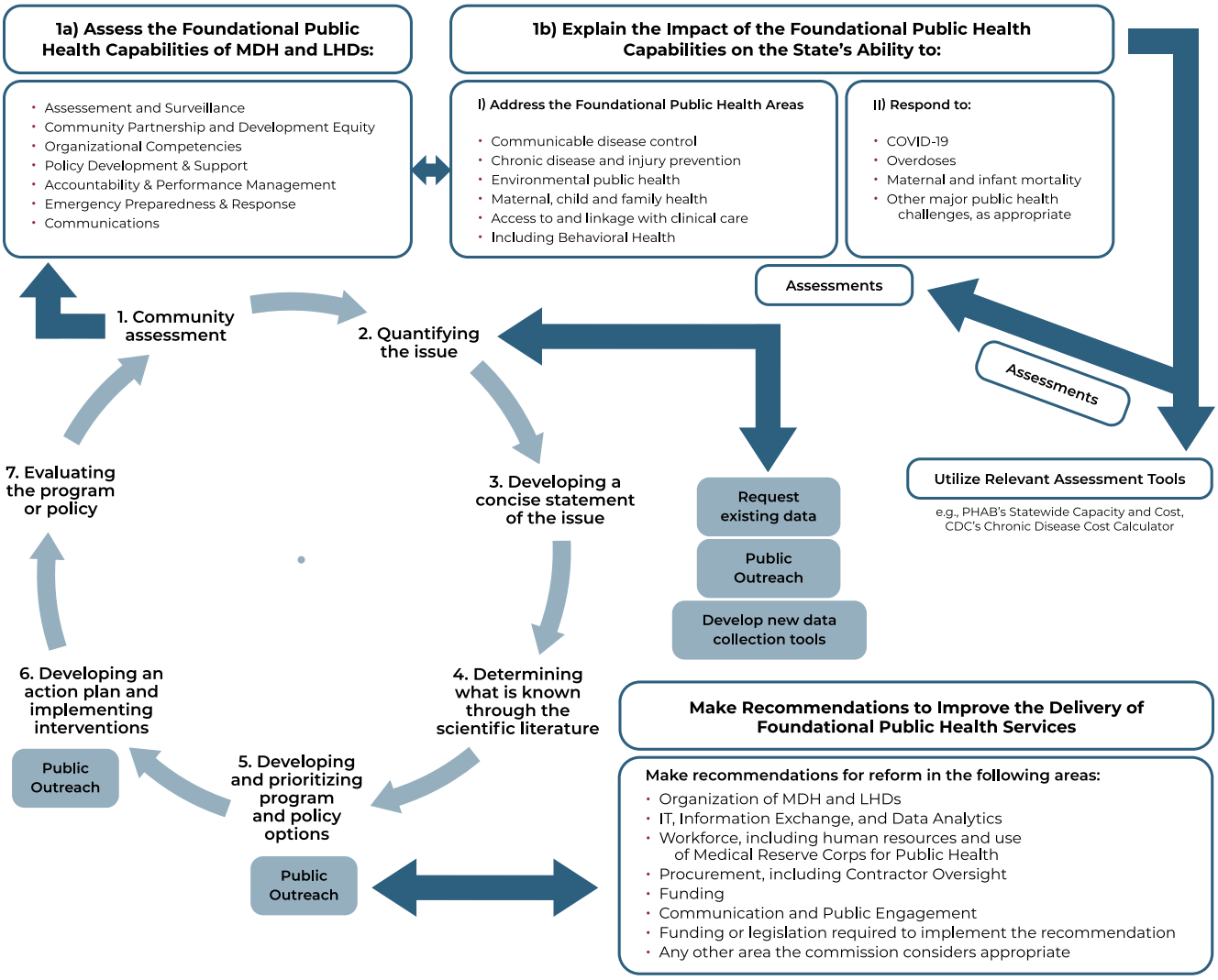
   The aim of the model is to guide the Commission's overall assessment and recommendation efforts, as well as the future work of state and local health departments around implementation and evaluation of specified recommendations. The framework is guided by the Evidence-Based Public Health (EBPH) model by Ross C. Brownson et al.;[5] the Foundational Public Health Services (FPHS); and capabilities per the Commission's legislation. It consists of seven constructs, including:

   1. Community assessment
   2. Quantifying the issue
   3. Developing a concise statement of the issue
   4. Determining what is known through scientific literature
   5. Developing and prioritizing program and policy options
   6. Developing an action plan and implementing interventions
   7. Evaluating the program or policy

   Together, these key components of the model framed the Commission's work by:

   - **Guiding decision-making** around the use of best available scientific evidence during literature review
   - **Supporting the utilization of data and information systems** systematically for assessment tools design, implementation, and evaluation in collaboration with the Commission's workgroups, academic partners, and other key stakeholders
   - **Applying the model to the FPHS and capabilities of Maryland's state and local health departments,** as specified in the legislation to best assess the state's unique strengths and issues
   - **Engaging the community in decision making** by incorporating input from residents, stakeholders, and local leaders through site visits, public listening sessions, public survey, and feedback opportunities to ensure recommendations reflected Marylanders' needs and priorities
   - **Disseminating what has been learned** through its final report, while proposing recommendations for a healthier and more prosperous Maryland

FIGURE 2. MARYLAND COMMISSION ON PUBLIC HEALTH CONCEPTUAL MODEL



4) **Academic Assessment:** The Commission engaged academic partners from Coppin State University, Morgan State University School of Community Health and Policy, and the University of Maryland School of Public Health to gather and synthesize information from a wide variety of sources. Using the Commission's framing questions, the University of Maryland School of Public Health academic partners created the initial and final drafts of the organizational survey, interview protocols for key informants, and focus group instruments. The academic partners from Coppin State University contributed both methodological and subject-matter expertise to the development of the organizational survey, key informant and focus group instruments; provided assessment advisory support and facilitated linkage with core external

organizations and stakeholders to be interviewed; supported final reviews of the assessment instruments; and led the creation of the commission's conceptual model described above in Section 3. The University of Maryland School of Public Health academic partners gathered confidential qualitative data through personal interviews from a variety of public health leaders in Maryland selected for their critical role in the public health infrastructure. They conducted 76 interviews with 104 individuals, including state officials, leaders of state-level agencies, commissions that address health-related issues, and advocacy groups. Individuals were asked questions related to their roles, responsibilities, and knowledge. To supplement the information gathered from the interviews, 12 focus groups were conducted on the following topics:

1. Academic partnerships
2. Environmental health
3. Assessment and surveillance
4. Human resources
5. Behavioral health
6. Injury and violence prevention
7. Chronic disease
8. Maternal and child health
9. Communicable disease
10. Public health emergency response and preparedness
11. Communication and public engagement
12. Public health nursing

The University of Maryland School of Public Health academic partners administered an organizational survey to collect primarily quantitative information on the structural and operational aspects of MDH and LHDs. The partners received responses from all 24 LHDs using an online survey between December 2024 and January 2025, and five MDH departmental responses between January and March 2025.

Academic partners from Morgan State University undertook the analysis of the public comments that were received from listening sessions, online comment portal submission, and voice messaging, as described below in Section 5. Additionally, the de Beaumont Foundation conducted a focus group with local health officers (LHOs) on the topic of workforce and implemented a nationwide Public Health Workforce Interests and Needs Survey (PH WINS) workforce survey that included MDH and 100% of LHDs in Maryland.

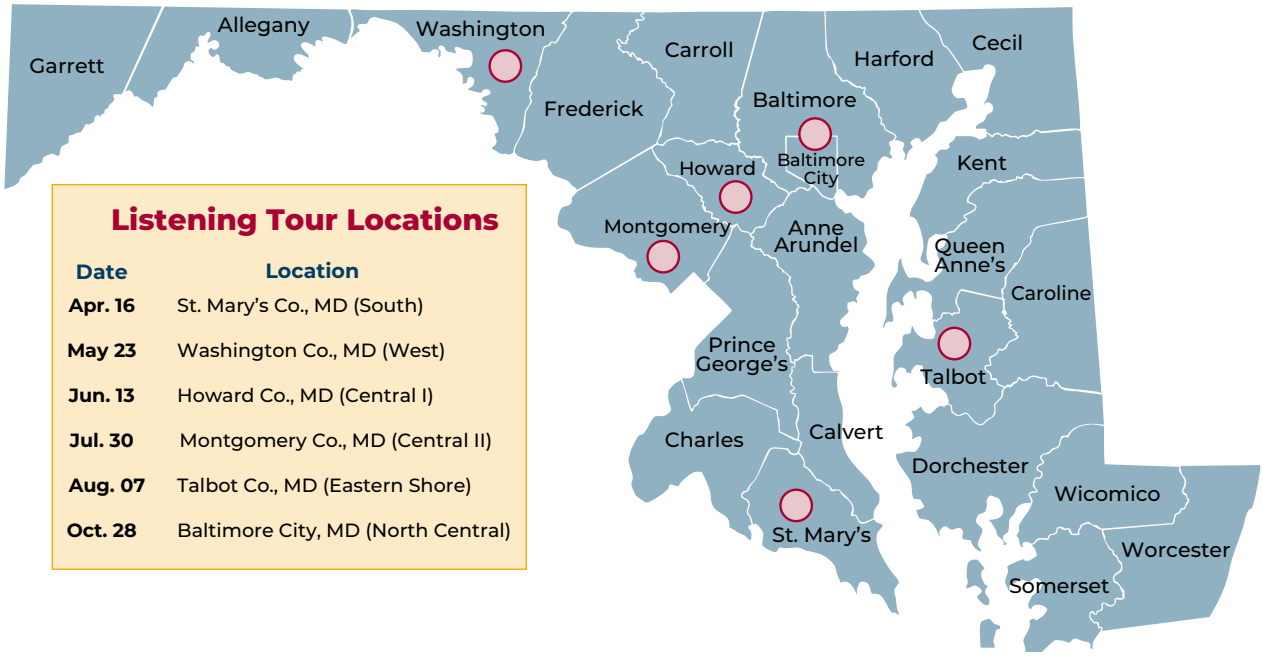
The academic partners presented their findings to the Commission in May 2025. The full report can be accessed on the Commission's website.[6] The Commission used the academic partners' information in developing and refining its recommendations and in developing the content of this final report. The final assessment report includes acknowledgements to all participants who contributed their time, the work-group co-chairs and members, and the Commission co-chairs.

Additional details about methodology for the academic partners' assessment activities can be found in Appendix 9.

5) **Public Feedback:** The Commission gathered feedback from the public in various ways. 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. 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 used social media platforms such as LinkedIn, YouTube, and Instagram to broaden its reach and ensure that Marylanders can stay informed and involved in this process. In conjunction with the LHD site visits, the Commission hosted six regional public listening sessions to learn from community members across various geographic locations. Most sessions were hybrid format and allowed virtual participants to provide commentary. LHDs provided American Sign Language and Spanish interpreters at each listening session. In addition to the public listening sessions, individuals could submit comments online or leave a voice message in English or Spanish.

6) **Site Visits:** The Commission completed six LHD site visits in different regions across the state to better understand the needs and dynamics of local public health services and how they may vary by jurisdiction. The host LHDs invited commissioners, workgroup members, and Commission support team members to participate, along with local elected officials and Board of Health members. The site visits were set in the same jurisdictions as the listening sessions.

FIGURE 3. LISTENING TOUR LOCATIONS



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)

7) **Draft Recommendation Public Comment and Response**: The Commission's statute required draft recommendations be posted for 30 days and any substantive comments be addressed in the final report. The Commission's synopsis and responses are included in Appendix 8. The Commission posted the draft slate of recommendations on June 9, 2025, and issued a press release along with social media posts highlighting the opportunity to provide feedback online and by voicemail. The open comment period closed July 10, 2025, at 9 a.m. and received 35 submissions, of which 31 were deemed substantive. Those 31 substantive submissions resulted in more than 180 discrete comments on recommendations. The Commission organized follow-up meetings with the public agencies and key statewide partner organizations that submitted comments. The Commission accepted more than 66 edits to the draft slate as a result. The comments came from individuals living or working in 15 jurisdictions (counties and Baltimore City) in addition to those outside of Maryland.

8) **Finalizing Recommendations and Adopting the Report**: Throughout the development and review of recommendations, the Commission used best efforts to reach consensus on the slate of recommendations as required by the statute. House Bill 214-2023 provided Commissioners the opportunity to file dissenting comments in instances where consensus was not achieved. After the adoption of the final slate of recommendations at the meeting on September 11, 2025, Commissioners were asked to file their comments with the co-chairs and staff by September 18, 2025, for inclusion in the final report. Commissioners were provided a template for ease of use and made aware that the dissents would be included in their entirety in the report. The co-chairs did not receive dissenting comments from Commissioners. The report was reviewed prior to the September 25 meeting and adopted by the Commission with direction to staff and the co-chairs to submit with noted modifications by October 1, 2025.

Top: Site Visit to St. Mary's Co.
Left: Site Visit to Washington Co.

SECTION 2

The Need

MARYLAND OVERVIEW

Maryland reaches from the Atlantic Ocean in the east to the Appalachian Mountains in the west. It borders four states and the District of Columbia. The state has diverse regional and county-specific health needs and healthcare capacity, rural and urban geographic differences with vastly different characteristics within local communities, and a rapidly growing variation in the population's sociodemographic characteristics. This geographic diversity reflects various occupations, weather, cultures, economies, and more. The state has experienced changing population trends over the past several decades. Most jurisdictions have significant variation in demographics and health challenges. Maryland considers 18 of its 24 jurisdictions as rural, although the majority of the population lives in primarily urban areas, particularly in the Baltimore and Washington, D.C., metropolitan areas.

> **"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."**

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 socioeconomic and racial lines. The state has a diverse population, with approximately 49.0% non-Hispanic White, 30.2% non-Hispanic Black, 11.1% Hispanic, 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.[7,8] Maryland also has a large immigrant community. In 2024, 17.1% of the population was foreign-born. There was a 40.9% increase among those 65 and older in the state.[9] Rural communities exist in Western Maryland, Southern Maryland, and on the Eastern Shore.[10] In rural counties especially, health services may be limited and transportation remains a major challenge.[11]

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 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities (Figure 4).

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 the 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 is considered a super-agency, since it includes other key state-level activities like Medicaid and Behavioral Health in addition to the Public Health Services.

FIGURE 4. THE 10 ESSENTIAL PUBLIC HEALTH SERVICES.*

*** From the Public Health National Center for Innovations and the De Beaumont Foundation. The Centers for Disease Control and Prevention website states, "The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions and enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. Everyone should have a fair and just opportunity to achieve good health and well-being." (https://www.cdc.gov/public-health-gateway/php/about/index.html).**

Maryland has **24 local health departments** (LHDs) operating in each of Maryland's jurisdictions, including its 23 counties and Baltimore City. All 24 LHDs have a local health officer (LHO) or, in the case of Baltimore City, a Commissioner of Health. This is a role, not a formal job title, that LHDs across the country have adopted as part of the CDC's high-achieving, collaborative Public Health 3.0 framework.[12] 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 twenty-four 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. The duties of a chief health strategist involve acting as an architect for community health and well-being, which means working collaboratively with various partners across different sectors.

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 BOH. Executive orders from Maryland's governor may also directly assign responsibilities to LHOs. An example of when this could occur is during a public health emergency. In most local jurisdictions, the elected county commissioners or county council serve as the BOH. These elected officials may have different experiences or knowledge relevant to health. Maryland does not have a state board of health.

Maryland's Public Health Governance Model

The U.S. Centers for Disease Control and Prevention (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 Officials (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.[13]

In addition to direct and pass-through federal dollars, as well as private grants, LHDs rely upon Maryland's statutorily defined state and local shared funding formula referred to as "core funding."[14] 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.[15]

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

The Commission recognizes that Maryland's public health capacity is highly dependent on federal agencies for health statistics, health education information, emergency preparedness and response, and programmatic funding. In addition, Medicaid funding provides an essential resource for the health of the state's population. Changes in the federal landscape may have a significant impact on public health services within Maryland. The Commission closely monitored developments since the change in federal administration and recognized that national shifts may affect the capabilities of Maryland's state and local health departments.

Foundational Public Health Capabilities and Areas

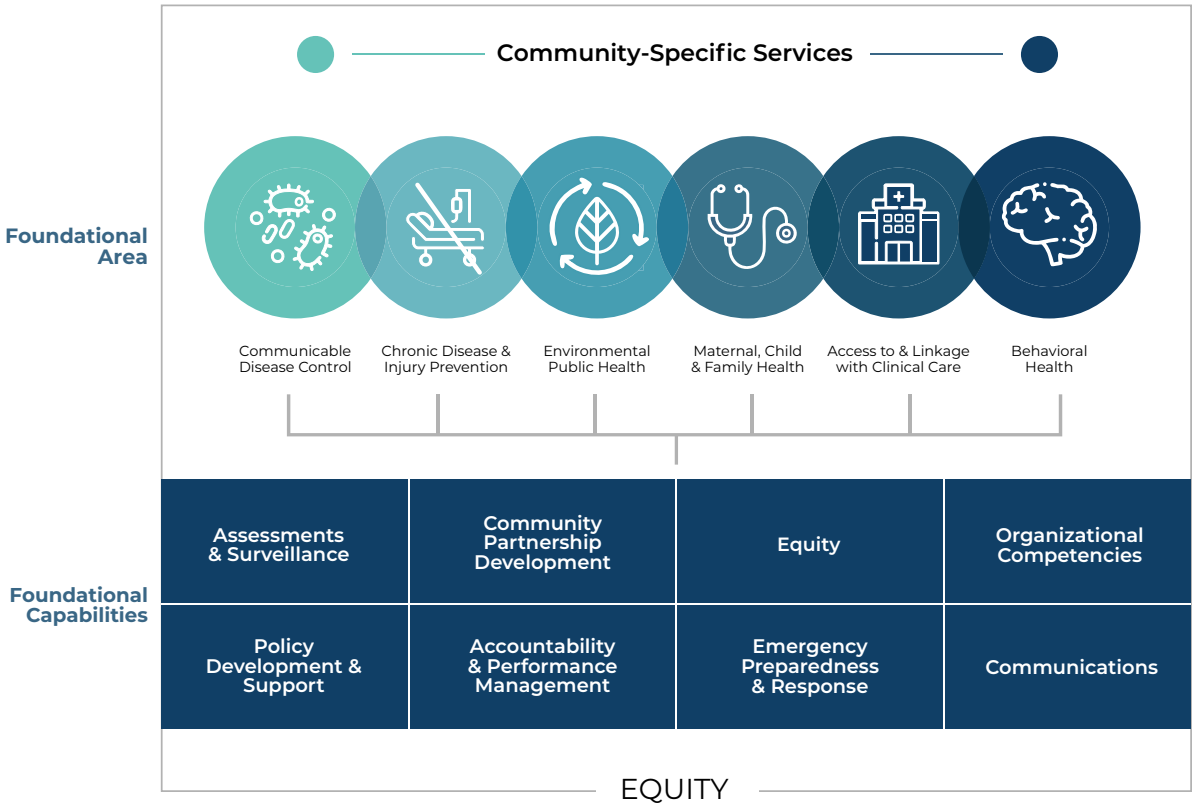
The Commission's authorizing legislation included the Public Health Accreditation Board's (PHAB) foundational areas and capabilities as a guide to inform its work and as a basis for making its recommendations. The foundational public health services (FPHS) framework that PHAB uses to accredit health departments includes foundational public health capabilities (FPHC) and foundational public health areas.[16] The Commission also added behavioral health as a Foundational Public Health Area in recognition of the extensive role that both MDH and all LHDs have in this topic, as well as its relevance to Marylanders' health and well-being.

As PHAB describes, "the Foundational Public Health Services define a minimum package of public health capabilities and programs that no jurisdiction can be without." The Commission acknowledged that the needs of communities vary by population and geography and additional capacity and services may be needed in different locales. The following are descriptions of the foundational public health capabilities which were used to inform the development of the Commission's framing questions for the assessment.

- **Assessment and surveillance:** Assessment means gathering and studying information to understand a community's health and what affects it. Surveillance uses this information to spot new health trends, risks, and problems so public health organizations can act. Assessment and surveillance are both key components of all population health work, which rely upon strong capabilities to collect, access, analyze, interpret, and use data.[17]
- **Community partnership development:** Community partnership development brings people and organizations together to tackle health challenges and create better opportunities for everyone. By working as a team, sharing resources, and listening to the community, public health agencies and their partners can make a real, lasting difference. One important strategy is service and resource sharing, where public health departments collaborate to share staff, tools, and expertise. By working together, they can reduce costs, strengthen partnerships, and ensure that essential services reach the communities that need them most, especially in areas with limited resources.[18]
- **Organizational competencies:** Organizational competencies help public health departments work well. This includes leadership and governance, which means making decisions, creating policies, and ensuring fairness; information technology, which keeps data safe and communication systems running; workforce development, which focuses on hiring, training, and supporting staff; and financial management, which handles budgets, funding, and keeping public health facilities running smoothly.[19]
- **Policy development and support:** Policy development and support means working with communities, organizations, and leaders to create and improve rules that help people stay healthy. It includes identifying health problems, helping to shape solutions, and making sure the solutions are put into action effectively.[20]

- **Accountability and performance management:** Accountability and performance management means making sure health departments run effectively, track their progress, and keep improving their services. It helps public health teams set clear goals, measure success, and make better decisions based on data.[21]
- **Emergency preparedness and response:** Public health emergency preparedness means being ready to respond to disasters, disease outbreaks, and other emergencies. Health departments plan ahead, work with partners, and make sure essential services can continue. They focus on protecting the people who are most at risk, keeping the public informed, and helping communities stay safe before, during, and after a crisis.[22]
- **Communications:** Public health communication ensures people get the right health information, at the right time, and in a way they can understand and trust. This includes working with local media, using social media, providing clear updates during emergencies, and promoting health through education and outreach. Good communication helps people make informed decisions and builds trust in public health.[23]
- **Equity:** Having an equity focus allows public health officials to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to reduce systemic factors that produce and reproduce inequities.[24]

FIGURE 5. FOUNDATIONAL PUBLIC HEALTH SERVICES



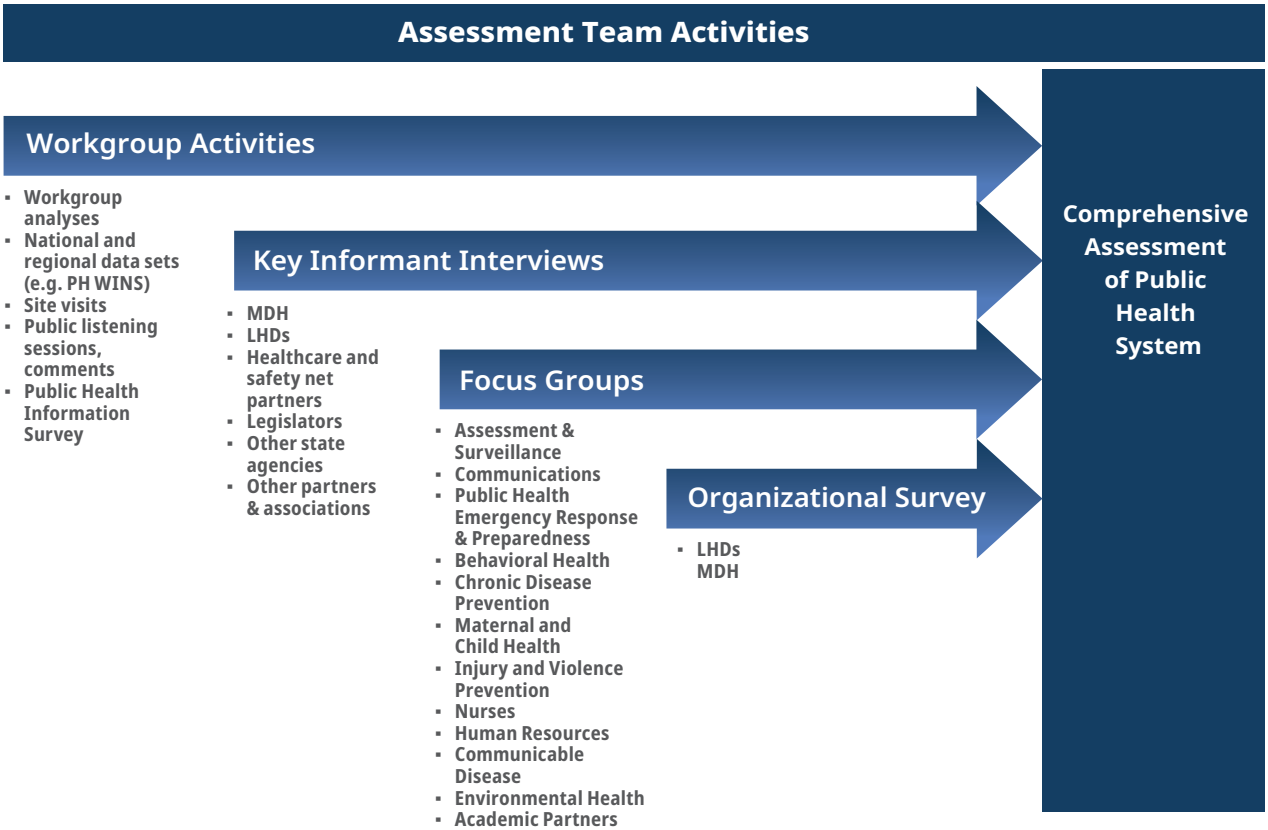
This is an adaptation of the FPHS Framework from the PHAB Webpage.

FINDINGS

The five Commission workgroups operated with a common understanding that key elements of effective governmental public health operations require clear governance and organizational structures; a skilled, multidisciplinary, diverse, and prepared workforce with a stable pipeline plan; timely data and information technology availability and resources; sufficient funding through state and local governmental funds and external funds; clear communication and sustainable public and community engagement; and partnerships.

Following is a summary of the Commission's key findings, categorized by the five respective areas of inquiry by the workgroups, as well as additional critical issues that emanated from our comprehensive assessment. This section ends with a discussion of three topics that were specifically mandated by the legislation to be examined by the Commission—namely, COVID-19 and our emergency preparedness and response; maternal and child mortality; and overdoses. Although these might seem like separate issues, the foundational public health service and system improvements the Commission is calling for can help Maryland more efficiently tackle all three issues and more. As a whole, the findings amalgamate the workgroups' work, Commission meetings and discussions, site visits, and the information presented in the Academic Partner Assessment Team Report[25] that included interviews with key informants, focus groups, public comments through online capture systems, voicemail, and testimony.

FIGURE 6. COMPREHENSIVE ASSESSMENT OF MARYLAND'S PUBLIC HEALTH SYSTEM



Governance and Organizational Capabilities

The Core of Maryland's Public Health System: MDH and LHDs

The core of public health activities in Maryland is centered in the governmental portion of the public health system, which comprises the Maryland Department of Health (MDH) and 24 local health departments (LHDs). Taken together, more than 7,000 individuals work in some capacity throughout this core fabric of Maryland's public health system, who are singularly dedicated to improving the health of Marylanders. The state is fortunate to have public health professionals at both MDH and LHDs who are highly skilled and knowledgeable. During the assessment process, individuals who held leadership roles external to the government recognized Local Health Officers (LHOs) as talented individuals who have a deep commitment to public service.

MDH provides funding, oversight, and coordination of state-level public health activities, while LHDs fulfill the foundational public health capabilities at the community level and, through their LHOs, serve as chief health strategists for their jurisdictions. In addition to programmatic activities and services, public health operations at both the state and local level include communicating with the public, monitoring health-related trends, securing and managing grant-funded programs, establishing partnerships and collaborating with stakeholders.

The shared governance model between MDH and LHDs presents strengths and challenges to LHDs. The shared governance model provides funding stability, professional expertise in specific areas, and needed alignment, but it can be difficult operationally. This variation in local autonomy adds operational complexity that can affect how efficiently LHDs respond to community needs. In jurisdictions that rely on state-level systems—such as centralized human resources processes—LHDs may need to follow additional administrative steps, which can extend timelines for hiring or program implementation. While these systems offer consistency and oversight, they can also create delays that impact the speed of local public health response.

The Commission's assessment identified the following key challenges:

Need to Enhance Capabilities

There is a desire to enhance core operational and management expertise at the state level to increase efficiency and ultimately improve the public health system's ability to fulfill its foundational public health capabilities. The state has a deep bench of expertise in a wide variety of public health areas, including maternal and child health, epidemiology, infectious disease control, emergency response, and chronic disease. However, LHDs have expressed a need for more assistance from MDH in several areas, including grant preparation, submission, and post-award monitoring; data procurement, management, analysis, and translation to inform data-driven strategic planning; development of comprehensive prevention plans; understanding of policies that affect community health; program evaluation; and workforce development and innovation.

Operational Challenges

The Governance workgroup identified that the level of oversight by the MDH involves significant bureaucratic complexities that slow the recruitment and hiring of personnel and grants management. With respect to personnel, for those LHDs that utilize the state personnel system, the state's Department of Budget and Management (DBM) sets the rules governing job classification, compensation, and recruitment and hiring processes. These rules must be followed at the local level when LHD employees are officially employed by the state. Several LHDs utilize the state personnel system for all their employees. Some LHDs exclusively use their

local jurisdictional personnel system (with the exception of the LHO, who is typically a state employee), while a smaller number have some state personnel and some county personnel. With respect to grants management, federal funds must flow through the state subdivisions before going to the LHD. Some DBM and MDH processes, including those related to hiring, are administratively burdensome and may slow the implementation of grant-funded activities and services. This in turn may slow how quickly grant funds are then mobilized by LHDs to their community partners.

Need for Clarification of Responsibilities

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. Complicated or ambiguous statutes at the state and local level result in instances where it is unclear where legal authority lies. Local Boards of Health (BOHs) provide an additional authority layer to the LHDs. There is concern that many BOHs do not include members with health or public health expertise.

Need to Improve Communication within Governmental Public Health

There is an expressed need for enhanced communication between MDH and the LHDs. More so because LHDs perceive communication with MDH as often unidirectional and feel that communications from the state are prescriptive directives without opportunities for constructive dialogue. The LHDs want opportunities to learn about the origins of operational policies and provide input on how decisions will impact the LHDs.

From the MDH's perspective, LHDs are sometimes unaware of the constraints under which MDH operates and the corrective efforts undertaken in response to LHDs' concerns. MDH holds a monthly meeting with the LHOs and involves them in several MDH and other state agency workgroups and committees.

While some communication mechanisms exist, clearer, more regular, timely, bidirectional dialogues would go a long way to alleviating current tensions between MDH and the LHDs. These communications could focus on news of upcoming opportunities, potential funding challenges, expected changes to policies and procedures, and programmatic developments and experiences. LHDs desire opportunities to share their vision with MDH for tailoring programmatic activities to meet the local needs of community members.

Many internal systems at the state level lack personal interaction, leading to delays and increased frustration. Technology does not always translate into more efficiency. The quality and quantity of current communication and dialogue forums are limited within MDH, and between MDH and several other state agencies and partner organizations. Several state agency leaders and health-related partners expressed a desire to enhance cross-entity communications. Direct personal communication is desired both within MDH and between MDH and other entities. The sheer volume of activities that are being implemented within MDH and across multiple state agencies that are responsible for health-related issues, coupled with workforce shortages, make communication difficult.

Need to Improve Collaboration and Communications with Governmental Public Health Entities

MDH is a super-agency. The MDH Secretary oversees the Public Health Services Administration as well as administrations for behavioral health, Medicaid, and other programs, such as the Maryland Primary Care Program (MDPCP). Numerous commissions (e.g., Maryland Health Care Commission [MHCC], Maryland

Community Health Resource Commission [MCHRC], Health Services Cost Review Commission [HSCRC]) play a critical role in advising and, in some cases, supporting community health and healthcare delivery initiatives. Numerous governmental agencies, as described earlier, are focused on outcomes that are related to public health. Clear communications and collaborations among these entities provide an opportunity to align efforts and document impact at the state, local, county, and community levels. A better understanding of the interactions among these activities and a clear picture of the nexus of common goals and health outcome metrics would allow for strategic collaborations and shared action plans.

Need to Expand Accreditation

PHAB accreditation would provide a path forward toward strategic planning and quality improvement at the local level, but some LHDs lack the resources to pursue accreditation. Half of the LHDs in Maryland are accredited by PHAB, 29% are exploring it, 8% are actively pursuing it, and the remaining 18% are not pursuing accreditation. Accreditation requires formalized accountability of activities and outcomes with data and strategic planning, both of which are variable across counties. Pursuing accreditation requires significant staff time, energy, and resources, which are limited due to programmatic demands.

Data and Information Technology (IT)

Importance of Data and Modern Technology Systems for Public Health

Health-related data is critical to operating public health programs in Maryland. Data is used to understand the prevalence of various health issues affecting the community. Epidemiologists and data analysts at both the state and local levels gather data to fully understand the health status of Marylanders and the factors contributing to their health status. Ultimately, the local data gathering efforts create an understanding of the health issues that affect community members. This data is also used to inform people about the design and deployment of targeted health initiatives. An effective data and IT infrastructure requires technological systems for program monitoring and administration, financial management, operations, and program evaluation.

The rapidly changing IT and data ecosystem in Maryland is insufficiently resourced to undergo regular updates and keep pace with innovation. Modernization efforts can be costly and sometimes disruptive; hence, accurate, accessible, and efficient data is crucial for informing public health policies, surveilling and managing outbreaks, and monitoring and improving community health outcomes.

The Commission's assessment identified the following key challenges:

Need to Build Better Systems to Support Data-Driven Decision-Making and Business Operations

Aging infrastructure and outdated technology are significant barriers to efficient public health operations. Many public health departments operate out of older facilities that lack the space or modern amenities needed for effective service delivery. The vast number of outdated data systems in use is extremely burdensome. Data systems and their outputs are not always designed to promote transparent, accessible, and equitable external communication that meets the varying needs of communities. Technological challenges arising from outdated electronic health records and insufficient IT support hinder efficiency. Health outcomes and policymaking are hindered by outdated privacy laws and regulations that fail to account for the high level of connectivity in the

21st century world. There is a need to improve the state's public health capacity to make projections related to health outcomes and estimate corresponding needs.

Need to Improve Data Access, Collection, Management, Analysis, and Utilization

Public health data is collected through many different systems, and accessing data from these systems is difficult and inconsistent across public health entities. There is a lack of effective alignment across all relevant agencies and service providers that operate under incongruent privacy laws, regulations, and workflows. Barriers to access and utilization include:

- Data access that relies on "who you know"—i.e., personal connections between health department staff and contacts at other departments or agencies
- New health officers and staff who might not be aware of all the data that currently exist
- Lack of data sharing agreement templates, or cumbersome data sharing agreements
- Difficulties sharing data across counties, even when patients travel across counties for care
- Privacy laws that make exchange of data difficult between public health, healthcare (Health Information Portability and Accountability Act [HIPAA]) and schools (Family Educational Rights and Privacy Act [FERPA])

Improved timeliness of data availability is needed to drive prevention strategies, messaging, and other public health activities. Epidemiologists present data to external parties, such as the public or elected officials, to highlight emerging trends and drive prevention initiatives. Knowing how and when to release this information is crucial. Dashboards are an efficient method for improving data access and transparency. MDH dashboards[26] are valuable assets. Having similar dashboards for local-level data would be welcomed for transparency and improving the timeliness of data sharing.

Many public health activities and programs are long-term endeavors that take many years for results to be seen. This delayed impact can create the impression of endeavors as unproductive or performance failures, which can create a disincentive for policymakers to support long-term efforts that require many years to produce outcomes. Delayed timelines for monitoring and accessing impact data further compound this issue.

Tracking Service Delivery

Tracking service delivery is necessary to understand the number of individuals who receive different types of services. However, the current data systems used to track service delivery have limited utility. Some systems cannot count both services and the people receiving those services. More efficient systems are needed that can answer all the following questions: How many individuals are receiving a service? How many times has the same person received a service? How many people who receive one service show up for another service? How many people are reached? Where are the service gaps? Answering these questions would require systems to be able to communicate with each other, across different types of systems and jurisdictions.

Limited Interoperability

The current IT infrastructure has limited interoperability. Data systems are disjointed, lacking the ability to "speak to each other," which results in duplicative data processes (i.e., entering the same data into multiple systems). This limited interoperability of current systems is inadequate for today's data needs. Having multiple data systems impedes public health experts' ability to connect and work efficiently at a systems level.

Electronic Health Records

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. Public health systems are highly specialized, but EHR vendors do not tailor their offerings to public health. Currently, there is no opportunity to bulk purchase or share the investment and training costs of EHRs. LHDs expressed a need for a single, universal EHR platform designed specifically for public health. The Chesapeake Regional Information System for our Patients (CRISP) is a sophisticated data system that collects data from patients who receive care from hospitals and providers in Maryland.[27] Support exists for expanding CRISP for use as a public health EHR platform. Moreover, approximately half the LHDs (46%) currently use an EHR platform that connects to CRISP but only about a third (33%) of LHDs have at least one EHR platform that has integrated billing capabilities.

Enhancing Information Technology and Epidemiologic Expertise

The current workforce lacks a sufficient number of individuals with contemporary expertise in information technology and data analytics. More individuals with expertise in these areas are needed. Only half of the LHDs currently have a dedicated epidemiologist or statistician on staff. Although 42% of LHDs reported they had at least one staff member with expertise in public health informatics, many expressed the opinion that finding, hiring, and retaining individuals with contemporary expertise in data management and analysis is difficult. Competing with the broader healthcare and technology industries for employees is challenging.

Lack of automation and data system coordination burdens the workforce at both MDH and LHDs. This outdated IT and data infrastructure creates unnecessary and redundant effort for the workforce, such as still requiring or demanding manual entry, using Excel spreadsheets, manually re-entering data from one system to another, and using unautomated systems.

Artificial intelligence (AI) has the potential to transform public health.[28] It also presents challenges for both MDH and LHDs that require the development of a regulatory framework that ensures the accuracy of information, promotes responsible use in analysis, and is overseen by qualified professionals. Building the public health workforce to include more professionals with expertise in AI and its utilization in public health and healthcare service delivery will be essential in the future.

Workforce

Current Status of the Public Health Workforce

A strong public health infrastructure in Maryland requires a large, diverse workforce with skills and expertise in a wide variety of disciplines, including community health workers, a variety of clinical professionals (e.g., nurses, physicians, dentists), epidemiologists, program implementation staff, communications personnel, environmental health specialists, food safety workers, and operational personnel (e.g., administrators; finance, human resources, supply chain and procurement managers, and human resources and information technology professionals). Maintaining a responsive workforce requires effective recruitment and retention, strategic personnel training (upskilling) and career development, and assignment flexibility.

Geographic Distribution and Diversity of Workforce

Building a diverse workforce that is representative of the community and understands the community it serves is a priority. Maryland is one of the most diverse states in the United States, and it is critical that the workforce can interact with multi-generational community members who are racially, linguistically, and socioeconomically diverse. In addition, today's workforce must also be able to interact with and reach community members with varying levels of proficiency and comfort with technology, and varying levels of knowledge about (public) health. They must be competent in a wide variety of communication methods to meet the needs of the public.

Challenges exist with recruiting, hiring, and retaining skilled professionals, which have serious implications for the success and effectiveness of public health programming and are a major vulnerability to Maryland's public health system.

The Commission's assessment identified the following key challenges:

Workforce Shortages

To address the continuum of public health activities, Maryland's workforce comprises individuals with backgrounds in a wide variety of disciplines, such as public health, nursing, behavioral health, medicine, dentistry, epidemiology, and law. It is becoming more evident that individuals with expertise in the areas of data management and analysis, AI, healthcare financing, and organizational change management are also critically needed to address contemporary challenges and maintain a well-functioning public health system.

Currently, among the LHDs, based on full-time equivalent (FTE), the largest segment of the workforce is nursing (i.e., registered nurses, licensed practical nurses, and advanced practice nurses), followed by office and administrative support staff, including program and project managers (see Table 2). The clinical workforce is significantly larger than the workforce of traditional public health occupations, such as epidemiologists and health educators.

Public health nurses are the largest group by occupation within the local health departments, but they feel undervalued by the state. More than 1,000 registered nurses, including LHDs that directly employ school nurses, advanced

TABLE 2. SIZE OF WORKFORCE BY OCCUPATIONS, TOTALED ACROSS LHDS

Occupation	FTE
Nursing (including RNs, LPNs, and APRNs)	1131.9
Office and administrative support staff	827.2
Behavioral health staff	547.8
Community health workers	491.6
Nursing aides and home health aides	402.4
Environmental health workers	328.3
Health educators	166.8
Oral health care staff	86.9
Animal control workers	64.3
Preparedness staff	54.6
Nutritionists	50.1
Epidemiologists	45.3
Public information professionals	43.0
Public health physicians	27.0
Laboratory workers	17.0

Note: These numbers reflect the total number of FTEs (Full-Time Equivalent) reported across 23 LHDs in Maryland who reported data by occupation in the organizational survey.

practice nurses such as nurse practitioners, and licensed practical nurses, work within the LHDs in Maryland, providing direct care, managing care coordination, and administering public health programs. Recently, the state adjusted the job requirements for care positions, either "downgrading" them such that a position that previously required a registered nurse can now be filled by a nursing assistant, or expanding them such that social workers, counselors, etc. can be hired. While the intent behind these changes might be to ease recruitment and hiring where shortages exist, some public health nurses interpret these actions to mean the state does not value or respect the specialized training and strengths that nurses bring to the table.

Workforce shortages are pervasive, and individuals with particular skillsets are in high demand. These shortages were exacerbated by the COVID-19 pandemic, during which many individuals with extensive work experience in the public health workforce either left their jobs or retired. Workforce shortages exist in four broad areas:

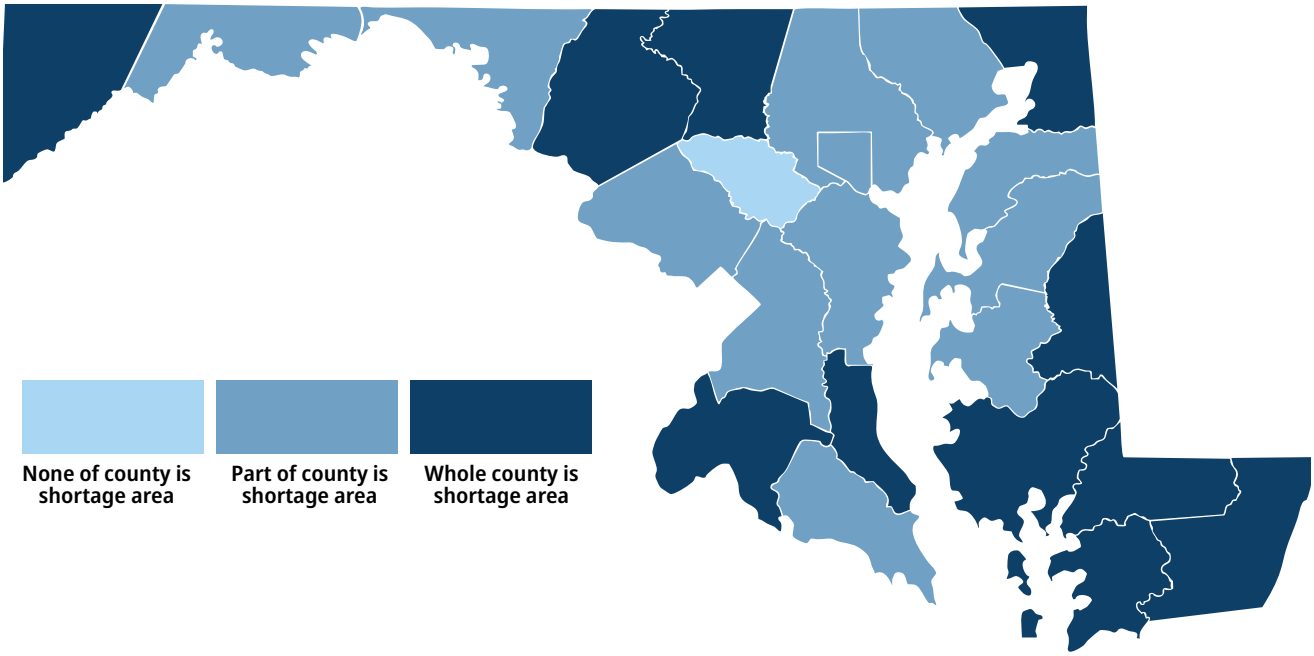
1. Individuals with expertise in core public health areas, including epidemiology, prevention science, and biostatistics
2. Health communication experts who can translate science-based information to counter the proliferation of inaccurate information and ease the public's distrust of public health
3. Clinical workers such as public health nurses, primary care clinicians, behavioral health clinicians, dentists, and addiction medicine specialists
4. Individuals with expertise in information technology and data management

These deficiencies in the workforce are further intensified by the need for the workforce to reflect the communities being served and adjust to meet rapidly evolving health needs and new technologies. The pipeline into the public health workforce needs to be expanded and intentionally nurtured. Sustained recruitment efforts are needed to broaden the reach for potential candidates for both state and local vacancies.

Some areas of the state are more impacted by workforce shortages than others. Rural counties such as those in Western Maryland and the Eastern Shore struggle to recruit and retain a workforce that is willing to commit to working and living in rural counties, particularly for workers who are early in their careers.

"Workforce shortages are pervasive, and individuals with particular skillsets are in high demand."

FIGURE 7. HEALTH PROFESSORIAL SHORTAGE AREAS, PRIMARY CARE, BY COUNTY, 2022[29]



Difficulties Recruiting Individuals for Public Health Work

The generation of individuals entering the public health workforce today differs significantly from earlier generations in terms of how they value work benefits. State positions do not hold the inherent value they had for earlier generations, which had a longer-term perspective on their relationship with their employers and where guaranteed future pensions were valued over high salaries. A large proportion of the current workforce prioritizes work schedule flexibility, telework options, and higher salaries over benefits such as retirement fund contributions. There is, therefore, a need to highlight benefits that extend beyond traditional benefits when recruiting and hiring. Recruitment for positions in state and local governmental public health is also compromised by competition with the federal government and private sector, as working in the state and local public health arena is associated with lower salaries and fewer benefits, making the positions less attractive to potential hires.

Administrative Impediments to Hiring Personnel

The ability to hire personnel is impeded by specific administrative inefficiencies and delays with Maryland's state human resources system. Hiring often takes months—for LHDs, the median time-to-fill ranges from 35 days to 215 days, and half of the LHDs have a median time-to-fill that exceeds 80 days. The number of steps and approvals required by the human resources system is extremely burdensome, resulting in delays during which qualified candidates are lost. The inefficiencies with the human resources system are frustrating for all individuals in management positions. These difficulties result in long-term vacancies and an overall instability in the workforce that compromises public health's ability to fulfill programmatic responsibilities and implement foundational public health capabilities. State systems provide economies of scale, but they do not reflect a modern approach to recruiting and talent acquisition.

Limitations of Current Job Classifications

The state job classification system has made it difficult to secure skilled, qualified individuals into jobs in the LHDs and MDH. Some positions that are needed in public health do not exist within the state's human resource system, and existing job classifications that do not adequately describe the position fail to attract the attention of qualified applicants. In some cases, job prerequisites are not aligned with the existing competencies of today's public health graduates.

Retention Issues: Non-Competitive Salaries, Limited Incentives, Professional Development Needs

Significant challenges exist in retaining skilled professionals. Reclassification, incentives, and promotional opportunities are extremely limited. The rigidity of job classification titles and supervisory policies affects promotion pathways and precludes offering competitive incentives. Limited pathways for promotion and advancement further deter candidates from staying in the workforce, thereby creating instability and inefficiencies. Variation in salaries and growth opportunities across the state and other sectors often pull professionals out of the field of public health. The effectiveness of programs can be impeded by instability in positions. Turnover places a huge burden on the remaining staff, leading to burnout. Rebuilding institutional knowledge and personal connections is a labor-intensive and time-consuming process.

A small but significant incentive would be to highlight and showcase the good work of individuals who have chosen governmental public health as their career choice. The dedication and passion of the public health workforce is extraordinary, given the environment in which they work. People who have done this work for many years do so because they believe in what they are doing and that their efforts are for the greater good. Appreciation and recognition of their compassionate mindset can aid in building morale among the workforce. New ways of publicly recognizing and incentivizing the workforce are needed.

Leadership, mentorship, onboarding training, and continuing education require improvement. Onboarding of new staff is often not adequate, usually due to competing demands of day-to-day deliverables and mandates. There is a need to build mentorship into the public health infrastructure at both the state and local levels. Strengthening onboarding and mentorship could help with retention and morale. Leadership or administrative management training is not common among the existing workforce, as public health or medical education curricula do not require it. The available promotions at MDH often move people from content expertise roles to supervisory positions, yet these content experts can lack supervisory training. Lack of strong supervisors can then lead to issues in retention. Additional professional development opportunities in topics specific to public health could be offered or supported by the academic public health partners in Maryland.

Need to Develop a Future Workforce

Investments must be made to provide early exposure to public health careers as early as possible, starting in secondary schools. Intentional pathways should be developed to entice young people who have interests in health and science, as well as government, policy, and information technology, to fill the needs of the future public health workforce in Maryland.

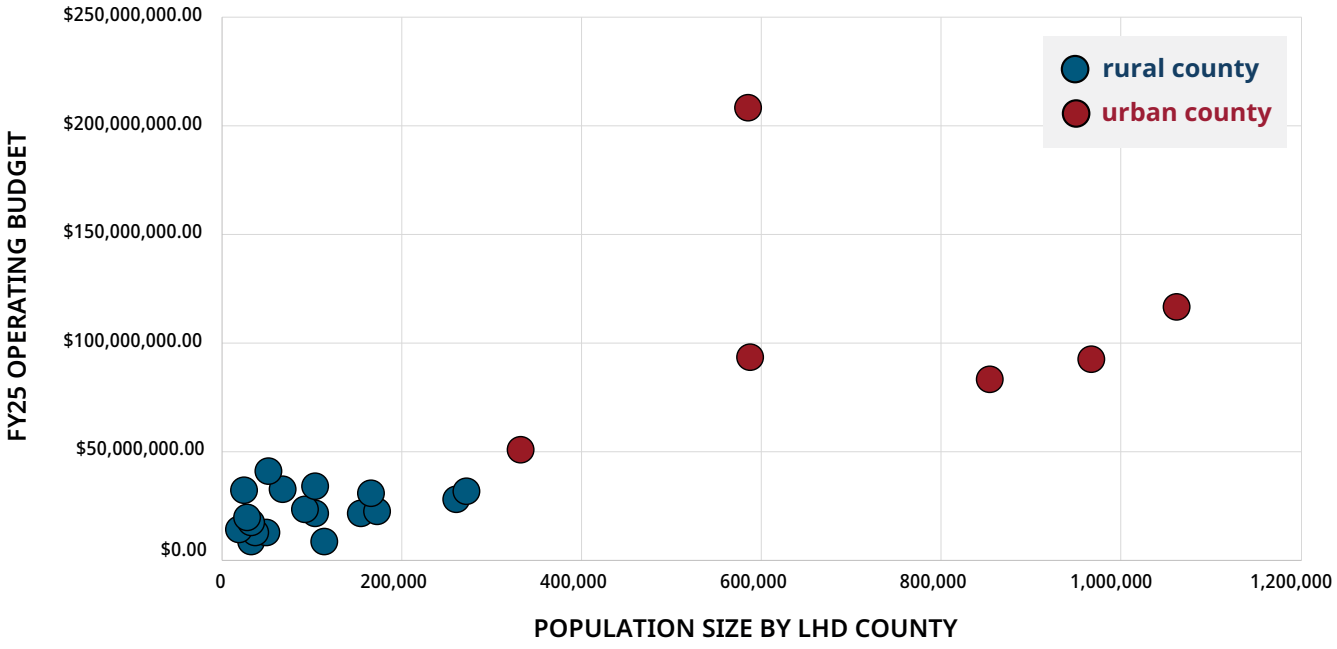
Funding

Current Status of Funding of Public Health

Concerns regarding funding for public health in Maryland were a common thread through almost all testimonies, speaker presentations, public meetings, and the interviews administered by the academic partners. The conclusion is that the current funding levels are insufficient to support the goals and responsibilities held by local and state public health officials and the labor and infrastructure costs of health departments.

The FY25 operating budgets among the LHDs vary widely from $8,600,000 to more than $200,000,000, totaling $1,060,000,000 across all 24 LHDs. The mean operating budget is $44,100,000, and the median operating budget is $29,700,000. Across LHDs, dependence on local or county funding ranges widely, from 5% to 71% of the operating budget. LHDs that receive less county support tend to rely more on insurance reimbursements and other state funding than other LHDs.

FIGURE 8. VARIATION IN LHD OPERATING BUDGETS BY POPULATION SERVED



The Commission's assessment identified the following key challenges:

Examining Core Funding

Core funding is a critical component of LHD budgets, as it is the only somewhat flexible source of funding LHDs can use to support administrative and operational functions (e.g., IT, communications, epidemiology/data analysis, grants management, fiscal operations, and human resources). However, relying on this funding model presents multiple significant challenges for the LHDs. First, current match rates were put in place nearly 30 years ago, and the original basis for determining the percentage match for each county is uncertain. The funding does not reflect the current needs of communities. Second, it is subject to extreme, unpredictable fluctuations and does not grow with other salary and fringe changes mandated at the state level for state employees. Third, core funding allocations for each jurisdiction do not account for the differences in underlying social determinants of health or health disparities across Maryland. Overall, the core funding formula does not adequately or equitably serve current public health needs for the LHDs. In fact, overall, core funding represents just 13% of the LHD budgets.

LHDs that receive less county support tend to rely more on insurance reimbursements and other state funding than other LHDs. Yet, contracting and billing insurance companies for services is a large administrative burden. Additionally, LHDs must have every insurance contract approved not only by the local BOH but also by the Secretary of Health. At times, the delays caused by this requirement lead to health insurance companies changing contract language (thereby

FIGURE 9. FINANCIAL SUPPORT FOR THE LOCAL PUBLIC HEALTH WORKFORCE: PERCENTAGE OF LHD EMPLOYEES SUPPORTED BY FUNDING SOURCES

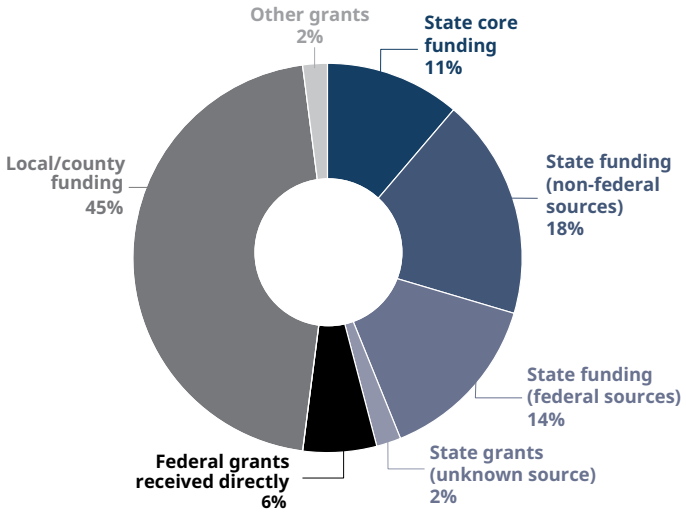
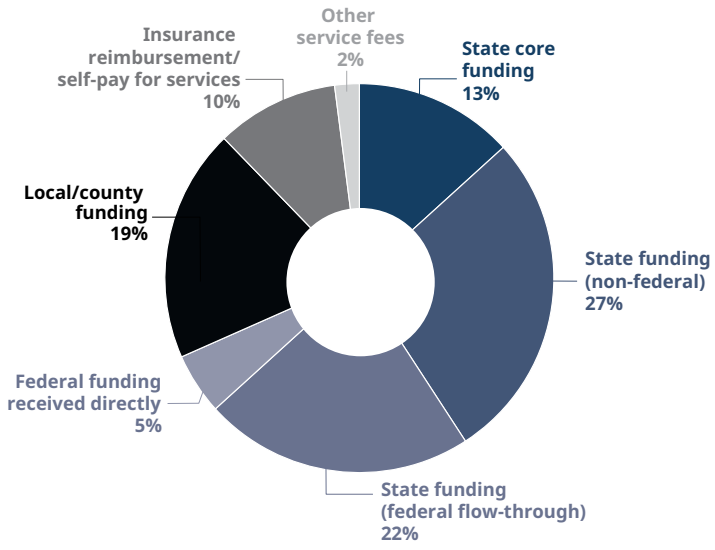


FIGURE 10. FINANCIAL SUPPORT FOR THE LHDS: FUNDING SOURCES FOR LHD FY25 OPERATING BUDGETS



forcing LHDs to restart the process and timeline) or "losing paperwork"—all of which further delay the ability of LHDs to bill insurance companies for billable services to their insureds.

In addition, service location impacts the level of reimbursement for certain types of services. Medicaid reimburses Federally Qualified Health Centers (FQHCs) at higher levels than those paid to LHDs for identical clinical services, even though LHDs serve the same income levels as FQHCs and have similar financial pressures to maintain access to care for the public. Clinical billing is complicated and time-consuming for LHDs. The lack of insurance contracts and well-qualified staff with necessary billing knowledge results in a failure to maximize collections for clinical services, inadequate oversight of budgets, and increased rates of non-compliance with requirements.

Expanding Sources of Funding

LHDs routinely seek funding outside of state and local tax revenue. They look to state, federal, and private grant sources for additional programmatic and operations funding. Maryland's healthcare landscape features significant investment in community health improvement through various channels—nonprofit hospital community benefit programs, community health needs assessments, the State Health Improvement plan (SHIP), the State Health Assessment (SHA), and grant-funded initiatives (e.g., opioid crisis grants, maternal health programs). However, these efforts can sometimes operate in parallel rather than in unison with local public health strategies. Reliance on grants also results in programmatic offerings that are determined by the availability of funding rather than the needs of the community. Identifying opportunities for integrating and aligning the planning and funding of this broader public health system could have strategic benefits. With this issue in mind, the Commission supports ways to align goals with the broader public health system. This points to strategic opportunities in collaborative planning and funding alignment.

Investing in the AHEAD Model

Maryland's continuing investments in value-based innovative healthcare delivery systems reform, now including the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model (population health, all-payor, primary care), provide a timely opportunity for collaboration and coordination between public health, primary care, and healthcare delivery systems on behalf of the public's health for the benefit of all Marylanders.

Enhancing Capacity for Procurement and Administrative Fiscal Operations

When seeking grant funding, LHDs are not always equipped to both conceptually develop proposals and administer the tasks required to obtain and administer a grant award. Few LHDs have the staff and software needed to write, track, and monitor multiple grants. State financial management systems fail to meet the needs of modern organizations, creating administrative challenges as personnel must adapt to inefficient or outdated processes. Once an LHD is awarded a grant, it faces numerous barriers. The 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 funds are returned, this may inadvertently signal that the funds were not needed in the first place and thus budgets and funding may be reduced in the future. These barriers can impede partnerships with community partners or funders if the LHDs cannot start services fast enough or maintain the revenue beyond a year. The preponderance of short funding cycles, namely one-year grants, further complicates this, as programs with short funding periods are often unable to collect meaningful impact data, which can negatively affect future funding opportunities.

Communications and Public Engagement

Communications and Public Engagement: Core Competencies of Public Health

Communication with the public has two broad goals: to disseminate science-based health information and to relay information about public health services and clinical care, both in plain language. Ongoing science-based messaging in clear language that is free from professional jargon, using terms the public understands, is critical to break through the vast amount of non-science-based messaging occurring daily. Public engagement includes the ability to listen and learn in order to design programs that are acceptable and available.

A wide variety of methods are being used to communicate with the public. Traditional methods, such as flyers and in-person engagement, are effective complements to digital strategies like social media.

Despite these efforts, much of the public is unfamiliar with the broad array of activities and services that constitute public health. Different populations have different needs, such as multilingual resources and culturally tailored messaging. The variety of languages that LHDs and MDH use (or strive to use) has expanded dramatically. Providing resources and information in the languages used by Maryland residents is critical for effective communication.

TABLE 3. COMMUNICATION TOOLS USED BY THE LHDS

Communication Tool	% of LHDs Using Tools
Print media (e.g., brochures, flyers, newsletters) distributed to organizations in the community	100%
Webpages with health information	100%
Facebook®	100%
Ads on broadcast media (TV or radio)	96%
Print media (e.g., brochures, flyers, newsletters) mailed to recipients	71%
Instagram®	67%
Electronic media (e.g., newsletters) emailed to recipients	67%
YouTube®	54%
Ads/posters in transportation settings (e.g., ads a bus stops, on buses)	46%
LinkedIn®	46%
X® (formerly Twitter)	46%

Note: Organizational survey data for n=24 LHDs.

The Commission's assessment identified the following key challenges:

Broadening Public Engagement

Mistrust in public health is a significant barrier to successful health-related communications. Public health's image problem has existed for some time but was significantly exacerbated by the COVID-19 pandemic. Issues remain with trust in public health broadly, and with health departments and public health officials more directly. A vast number of health information sources and online media do not always reflect current or accurate information. Health information and recommendations are often viewed with high levels of skepticism and negativity. With this proliferation of inaccurate information, it is more important than ever to be proactive in defining and explaining to the public the value of public health, including its goals, methods, and activities, as well as its impact. Health departments struggle to find successful communication approaches to overcome the misrepresentation of scientific evidence. Translation of scientific evidence remains a high priority, but a constant challenge. This mistrust in public health creates significant challenges to communication, presents a barrier to accessing appropriate care, and impedes the public from following scientifically based guidance.

Dialogue needs to happen regularly, with both the communities and with community champions, not only when there is a crisis or an ask. Unidirectional communication is not public engagement. Communication campaigns and other health messaging provide information to the public, but they are not always designed with input *from* the public. Engagement with the public is an essential ongoing activity that requires trained and supported personnel. Such engagement could mitigate mistrust and improve receptivity to public health messaging.

"Dialogue needs to happen regularly, with both the communities and with community champions, not only when there is a crisis or an ask."

All LHDs currently provide resources in Spanish, although some expressed a need to expand the resources they provide in Spanish. State and local health departments need additional resources to translate information into different languages to reach other communities, particularly those using Haitian Creole, Mandarin, Cantonese, and Arabic. Translation service costs are not always covered by grants. While progress has been made, many challenges remain to reach subpopulations and successfully align messaging with local contexts to ensure maximum impact. Some groups are harder to reach than others and require intensive efforts to disseminate information. Many local news sources are drying up (e.g., local newspapers shutting down or publishing less frequently), and it can be difficult to distribute local information or know how and where it will be seen.

In-person events allow for more conversations with community members. Over-reliance on online communication can be limiting and unreliable because social media evolves so quickly, and it is difficult to predict whether a post will be seen by many or only a few. "Old school" methods of face-to-face communication during in-person events must be part of any public health communication strategy.

Need for Regular and Clear Communication

Good communication is predicated on good relationships. Partnering with relevant and "trusted" messengers and influencers is critical for building a trusted relationship with the public. Sometimes the same health message will be better received when it comes from a community partner—ideally a community champion—than when it comes from the health department. This has become even more important in the current environment of mistrust described above. Building trusted partnerships is an ongoing endeavor; communications must happen throughout the year to solidify relationships so that they endure during times of stress.

Sharing data and facts is not enough. Information must be made relevant through stories and lived experiences. Collecting and reporting data are core mandates for public health professionals. However, data can feel abstract. Compelling testimonies and real-life examples from constituents or advocacy groups provide weight to the message and present complicated information in accessible and understandable formats. They help translate public health from the population level to the impact on the individual.

> **"Compelling testimonies and real-life examples from constituents or advocacy groups provide weight to the message and present complicated information in accessible and understandable formats."**

Communications and relationships with elected officials must be strengthened. Elected officials desire information that is compelling and clearly demonstrates the need for public health activities. Some legislators expressed that they are not aware of LHD budget constraints, and they would welcome more information. If they are not aware that investing in prevention and prioritizing public health is important to better health outcomes, funds will not flow to public health.

Enhancing Communications Expertise and Methods

Effective public communications significantly add to the workload of public health workers; the engagement of experts in health communications and health literacy is highly desired. Overall, the complexity of communications in the world today has added enormous burdens to public health work, and the field has not been able to keep up in terms of resources, funding, or staffing. One-quarter of LHDs do not have a dedicated communications team or public information officer (PIO). Often, there is only time for a flyer or a social media post. In some instances, there is little time to update websites and fix expired or broken links.

Evaluating the Impact of Communication Strategies

Evaluation of communication methods and campaigns is lacking. Public health communications competencies do not explicitly align with the marketing and promotion strategies required to engage the public. Health promotion, communications, and marketing are under-resourced and are not always an allowable expense or item in grant applications. In addition, it is sometimes challenging to evaluate the impact of certain public health communications.

Partnerships

The Critical Role of Partnerships in Maryland's Public Health Infrastructure

Partners support and enable both MDH and the LHDs to deliver foundational public health services. A wide variety of partners (e.g., state government agencies, community partners, and healthcare organizations) collaborate closely with MDH and LHDs and serve in various capacities to make service delivery possible and enable communications to the public. A critical partner to LHDs is the Maryland Association of County Health Officers (MACHO), providing essential networking, shared learning, and quality improvement opportunities. The wide variety of partners in Maryland support public health by:

- Providing extra personnel and expertise
- Connecting and providing trusted outreach to priority populations
- Providing support space for hosting events, seminars, testing, clinics, vaccination sites, etc.
- Conducting community needs assessments
- Sharing health-related communications
- Providing and accessing data to supplement LHD data
- Supporting the needs of priority populations
- Advocating for healthy communities
- Developing new technologies

Partnerships with healthcare associations and providers are strong and an essential link between prevention and care/treatment. LHDs and MDH have a wide range of beneficial partnerships with care providers, including primary care providers, dentists, emergency medical services and emergency departments, Federally Qualified Health Centers (FQHCs), school-based health centers, hospital systems, and behavioral health treatment/recovery-oriented organizations.

LHDs have strong partnerships with numerous local community partners and organizations and rely on these partnerships to help facilitate and support their efforts. These partnerships are essential to their work and help them connect with communities and maximize resources. These partnerships have been formalized into Local Health Improvement Coalitions (see Table 4).

Partnerships between state and local public health entities and businesses in the private sector are also emerging, especially after the pandemic. Successful partnerships have been forged between LHDs and the business community through membership in the Chamber of Commerce or by working with pharmacies**.** Fostering a sense of partnership with community members and populations is needed. Community partnership development extends beyond collaboration with established entities to include establishing partnerships with community members and populations. This requires members of the community and populations impacted by inequities to be involved in decision-making.

TABLE 4. LOCAL HEALTH IMPROVEMENT COALITIONS SERVE AS FACILITATORS OF PUBLIC, PRIVATE, AND NON-PROFIT PARTNERSHIPS FOR IMPROVING LOCAL PUBLIC HEALTH

Allegany County	Allegany County Health Planning Coalition
Anne Arundel County	Healthy Anne Arundel Coalition
Baltimore County	Baltimore County Health Coalition
Baltimore City	Baltimore City Local Health Improvement Council
Calvert County	Healthy Calvert
Caroline County	Mid-Shore Health Improvement Coalition
Carroll County	The Partnership for a Healthier Carroll County
Cecil County	Cecil County Community Health Advisory Committee
Charles County	Partnership for a Healthier Charles County
Dorchester County	Mid-Shore Health Improvement Coalition
Frederick County	Frederick County Health Care Coalition
Garrett County	Garrett County Health Planning Council
Harford County	Harford County Local Health Improvement Coalition
Howard County	Howard County Local Health Improvement Coalition
Kent County	Mid-Shore Health Improvement Coalition
Montgomery County	Healthy Montgomery
Prince George's County	Prince George's Healthcare Action Coalition (PGHAC)
Queen Anne's County	Mid-Shore Health Improvement Coalition
Somerset County	Healthy Somerset
St. Mary's County	Healthy St. Mary's Partnership
Talbot County	Mid-Shore Health Improvement Coalition
Washington County	Healthy Washington County
Wicomico County	Wicomico Local Health Improvement Coalition
Worcester County	Worcester County Health Planning Advisory Council/Local Health Improvement Coalition

Partnerships between state and local public health entities and the K-12 school system are integrated into the public health infrastructure and are functioning well. Many fruitful collaborations have developed between LHDs and K-12 schools, including establishing school-based health centers, employing school health nurses, and implementing early intervention programs to effectively address developmental delays at an early age.

Public health education in Maryland is very strong, with four accredited schools and programs of public health; numerous other undergraduate and graduate public health or related programs; community college

health-related programs; schools of medicine, nursing, dentistry, and social work; Area Health Education Centers; and a variety of other allied health professional training organizations to build Maryland's public health workforce. These institutional assets provide a student pipeline to governmental public health as well as foster partnerships with faculty and other professionals with specialized expertise.

Need to Maintain and Strengthen Partnerships

Increased communication and data sharing would strengthen all partnerships. A lack of communication and data sharing can hinder partnerships. Implementing open communications and a secure information-sharing system could enhance both partnerships and the efficiency of services provided.

Many funding opportunities emphasize partnership and collaboration. Funding opportunities that require or encourage partnerships are increasingly used to incentivize partnership development and to maximize the impact of resources. LHDs often act as passthroughs to the partners, who rely heavily on that funding.

While some mutually beneficial academic collaborations exist between MDH and the LHDs and both undergraduate and graduate educational programs, strengthening and expanding these partnerships is desired. Additionally, pipelines beyond what is strictly considered "public health," such as computer science or information technology, must be fostered. Key factors when developing these partnerships include the level of faculty involvement, faculty oversight of students, the availability of stipends or credits, and the health department's ability to supervise on-site.

Maryland's health-related associations want to be more helpful as partners. There was a clear desire among several health-related professional groups in Maryland to increase their collaboration with MDH and provide advice regarding the development and implementation of large public health initiatives.

Shifting Gears from Reactive to Proactive Strategies—Preventive and Primary Care

The national healthcare delivery system remains heavily focused on acute care, procedures, and diagnosis-based interventions. The system is set up to be reactive—a sick-care delivery system—and not as a system that proactively prevents disease. Prevention-oriented strategies are often insufficiently funded. Maryland's unique Total Cost of Care (TCOC) Model, administered by the Maryland Health Services Cost Review Commission (HSCRC), aims to reduce re-admission rates in hospitals by incentivizing them to prevent hospitalizations where they are deemed to be preventable. Maryland is leading the nation with the creation of the Maryland Primary Care Program (MDPCP). We have an opportunity to lead the nation in designing a robust public health infrastructure that works in concert with hospital care and primary care to prevent disease. In short, we can keep many people out of the hospital for costly services if we do our job right, producing a high return on our investment in public health. The Statewide Integrated Health Improvement Strategy (SIHIS) contains more details on the model and its successes in reducing healthcare costs. There are numerous opportunities for the public health sector to partner with the state in these efforts, with the shared goal of improving population health through community-based preventive strategies.

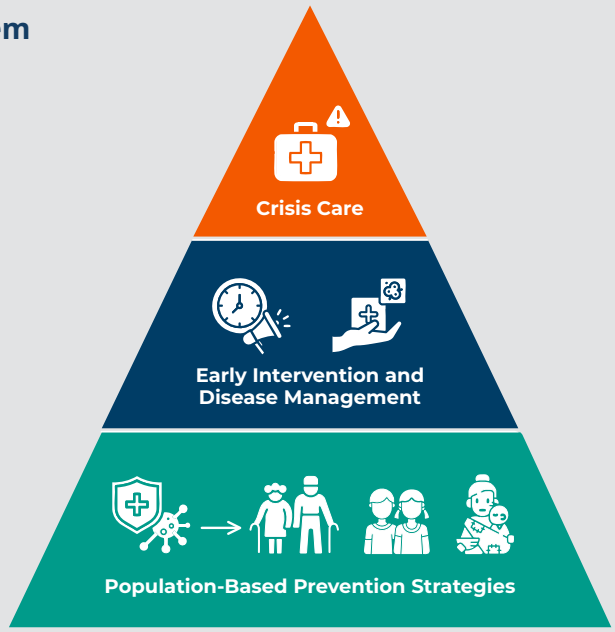
Righting Imbalances: Achieving Health for Everybody

Maryland's diverse public health, regional and county-specific needs, and rapidly growing variation in the population's sociodemographic characteristics require flexibility in approaches and human, fiscal, and technological resources. There are healthcare capacity and geographic differences that affect the services offered. 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 socioeconomic and racial lines. Health disparities are clear and unquestionable. This calls for investment in more detailed local, county, and community data.

Health equity work at the state and local levels takes place through both formal and informal mechanisms. The MDH Office of Minority Health and Health Disparities was established through legislation in 2004 with the priority of addressing health equity and reducing disparities in access to care in Maryland. Designing and implementing initiatives meant to address health disparities depends on the input of the impacted communities. At the other end of the healthcare continuum, hospitals and their member associations have aimed to address health disparities in all their work since it was highlighted in the Healthy People 2030 disease objectives. Initiatives to improve access for underserved populations, such as increasing transportation options, using mobile health units, providing translation services, conducting outreach to rural and migrant populations, integrating cultural competence in service delivery, and ensuring representation of diverse communities in program planning, are all important strategies to achieve health across all communities. To secure lasting improvements, work must begin upstream. Funding, resources, translation services, and data collection remain a challenge.

FIGURE 11. SHIFTING GEARS FROM REACTIVE TO PROACTIVE STRATEGIES

- **National context—the "sick-care" system**
- **Marylands's efforts to reduce healthcare costs**
- **Access to primary care is "the crisis no one is talking about"**
- **Prevention-oriented strategies are insufficiently funded**
- **Data systems are needed to identify cases early**
- **Proactive communication with policy makers is needed**
- **Widespread recognition that additional emphasis on prevention is strongly needed**



Addressing health inequities depends on equitable access to healthcare services. Gaps in access to specialty care and preventive services are ongoing challenges in Maryland. Expanding unemployment health insurance and reimbursements for individuals on a fixed income could be beneficial. Lack of access to transportation is also a key barrier to achieving health across Maryland. In rural areas of the state, such as Western Maryland and the Eastern Shore, transportation is especially limited. Other areas of the state have large populations that lack personal access to automobiles and must rely on public transportation.

Data is essential for everyone to achieve health. Community health needs assessments and other data collection methods should not only describe the extent of a problem but also illuminate the social determinants of health and contextual factors that give rise to inequities. If the necessary data is not collected, we lose the ability to assess the problem, determine who is impacted, and measure the impact of an intervention. If you do not measure the problem, you cannot measure the success. A full picture is impossible without data. With more data, public health officials can drill down to see details and understand nuances. It helps them identify those who are impacted and develop better policies and interventions. It allows for targeted efforts that ensure we are good stewards of funds. Wonderful programs do not always work for wide swaths of the population. For example, if a program distributed materials to enable telehealth in areas where many are without broadband, or to populations who might not be comfortable using telehealth, it will leave many behind and can leave people feeling more isolated. Data helps the public health system to allocate resources both equitably and effectively.

Selected Health Issues

As required by legislation, the Commission explored the impact of the foundational public health capabilities on the state's ability to respond to the three public health issues: 1) Emergency preparedness and response, including COVID-19; 2) Overdoses; and 3) Maternal and child mortality. The Commission noted that the latter two end-stage outcomes are preventable with sufficient support and system-level approaches.

These three areas were, in essence, case studies that informed a more intensive and urgently needed look at Maryland's foundational public health capabilities and the related recommendations. These and other emerging areas, such as the public health implications of environmental changes, require continued and more extensive future exploration.

Emergency Preparedness and Response, Including COVID-19

During the assessment process, officials at both MDH and other state-level agencies identified many logistical weaknesses that hinder emergency readiness and response. The state faces challenges in aligning strategies with the unique needs of diverse local jurisdictions. The COVID-19 pandemic underscored the importance of robust readiness for any type of widespread disruption that could have health consequences, including natural disasters, cyberattacks, bioterrorism, and infectious disease outbreaks. Opinions differ as to Maryland's preparedness for the next pandemic. Many LHD and MDH staff feel "battle ready," prepared, and drilled for an infectious disease outbreak. Others are very concerned that Maryland is underprepared, especially for a widespread and enduring event.

MDH leads public health emergency planning at the state level and provides essential guidance and support to local jurisdictions. LHDs rely on state guidance and support for emergency responses. Localized, time-limited

emergencies are easier to manage than widespread, ongoing emergencies, such as COVID-19, where everyone was competing for the same resources, and which prohibited reliance on others for help. The first actions taken in a potential emergency can be crucial, and it is important to bring all LHDs up to a preparedness standard. As a senior MDH leader expressed, "all emergencies start local."

Funding associated with the pandemic enabled some infrastructure improvements, but as these funding streams cease, the ability to prepare for and address other public challenges is impaired. The time to accelerate our efforts to fund and deliver on our promise as leaders to promote the health of the public has never been more urgent. Maryland's dependence on federal funding for emergency preparedness and response is an enormous vulnerability. The Office of Preparedness and Response, as well as all infectious disease programs at the state level, currently function on federal funds, not state funds. These federally funded programs and Maryland's response capability are at risk if the federal source funding is eliminated or reduced.

Preparedness and response require the coordinated effort of many entities, including MDH, the LHDs, the Office of the Governor, and the Maryland Department of Emergency Management. Given the number of entities involved, chains of command must be clarified, and communication channels among the different entities involved need to be clarified, strengthened, and maintained. That work must happen during non-emergency times to ensure preparedness. Additionally, clarifying the roles and expectations of the health departments and healthcare providers and identifying any overlap would be beneficial to avoid disruptions and miscommunications.

Drills and Training

Drills and training are essential for readiness but challenging to conduct. Implementing more drills, both tabletop and full-scale exercises across the state, is crucial for increasing preparedness and ensuring that all new staff have participated in drill training. Full participation is crucial to the success of the drills, but it can be hard to get all partners on board. Variability exists in available local resources among the LHDs. Some LHDs are located in counties with robust emergency operations centers that serve as valuable resources during emergencies, but not all counties have these centers. Not all counties have a mass distribution site or facilities for call centers. Having an incident command structure or plan in place is important because events can unfold rapidly in an emergency.

Risk Assessment Needs

Risk assessment and bolstering community resiliency are part of preparedness. The primary focus has been on the readiness of the public health infrastructure to respond to emergencies. One perspective not emphasized, but noted, was that preparedness should include risk assessments to identify population vulnerabilities and responsive strategies that could bolster the resilience of particularly vulnerable communities when an emergency arises.

Workforce Shortages: Impacts on Preparedness and Response Capabilities

Personnel for preparedness and response remains a challenge. Staff and expertise shortages contribute to deficiencies in readiness to respond effectively and promptly to public health emergencies. The loss of staff during and after the COVID-19 pandemic has caused lasting shortages. For the staff that remain, opportunities exist to reduce the burden of readiness training. Ongoing communication within MDH, between MDH and

LHDs, and among LHDs could identify opportunities for collaboration and the sharing of ideas on training and readiness. In times of emergency, deploying or reassigning personnel from one area of the state to another can be difficult and is a missed opportunity.

Volunteer Coordination and Deployment: Need for Improved Surge Capacity

The current methods for temporarily deploying personnel to other areas within the state during an emergency are insufficient to meet the needs of public health emergencies. This includes deploying state employees, non-state employees, or volunteers from one LHD or region to another region where more support is temporarily needed for an emergency response. The Maryland Responds Medical Reserve Corps (MRC), administered by MDH, is a community-based, civilian, volunteer program that helps build the public health infrastructure and response capabilities of communities in Maryland. Unfortunately, MRC and other volunteers are underutilized. Volunteers are an essential component of emergency preparedness and response. Some LHDs that had access to volunteers during the COVID-19 pandemic were able to effectively offset delays in hiring or transitioning to contractors or other employees. There is a need to explore additional partners and volunteers: retired military veterans, AmeriCorps, public health, nursing, or medical student volunteer networks. It is important to have local volunteer networks ready to jump into action. Investment in funded volunteer coordinator positions could improve readiness and efficiency, as there are no resources currently for volunteer coordinators. Ideally, an emergency preparedness response system should have built-in mechanisms to keep basic services operational during crisis situations.

Partnerships for Support and Logistical Assistance

Partnerships at the community level are also an essential component of preparedness and response. LHDs emphasized the importance of partnerships for community support and to buffer staffing attrition and shortages. Localized knowledge and community connections make partner organizations invaluable in emergency preparedness efforts, though additional resources are needed to enhance their capabilities. However, some community partners expressed feeling burned out and overburdened.

COVID-19 was frequently mentioned in public comments. The relevant foundational capabilities identified from public comments include communication, data-driven decision making, policy development, and legal analysis. There is concern that current strategies and messaging are inadequate. Several expressed the elimination of mask mandates in healthcare settings as a failure of public health. In reviewing Maryland's COVID-19 response to gain insights and assess future readiness, the necessary key elements include trained staff, strong communications systems, solid partnerships, and equipment infrastructure.

Deficiencies in the integration of lab processes and infrastructures could challenge emergency responses. Improvements have been made in some areas, such as automating data surveillance and reporting systems. However, many challenges remain, including a lack of interoperability of the data systems; a lack of integration of lab and surveillance data; a lack of modernization, with some laboratories still relying on sending reports by fax; timeliness concerns; and repeated unsuccessful transport of specimens reported from certain geographic areas of the state.

Maryland needs to prepare for the politicization of future emergencies and responses. The politicization of COVID-19 negatively impacted the ability to respond to the pandemic. Some counties required assigned law enforcement details for protection. A state statute that protected public health workers was not passed.

Although pandemics have happened throughout history, the COVID-19 pandemic created unprecedented challenges to our national and global public health infrastructure. Tragically, the pandemic resulted in more than 15,000 deaths in Maryland.[30] The pandemic was a stress test for Maryland—certainly for our emergency response systems, but more broadly for our ability to lead, work collaboratively, and communicate, both internally and externally.

Lessons Learned from COVID-19

One of the lessons learned from the COVID-19 pandemic was the need for a rapid and fluid communication system between all levels of the public health infrastructure. The pandemic positioned everyone in a reactive mode under intense pressure. State leadership's responsiveness and swift issuance of key decisions were undertaken to protect and serve Marylanders. However, LHDs often felt they were placed in difficult positions because state leadership (such as the Office of the Governor or MDH) publicly announced decisions or plans without giving the LHDs advance warning. The LHDs were then caught off guard, which contributed to public distrust and dissatisfaction with public health officials. The response sometimes appeared disorganized and disjointed, with officials not appearing to be on the same page. If state leadership had been able to inform the LHDs and other local officials beforehand, unified messaging and plans could have been prepared. Learning from this experience, future emergency planning should include thorough preparation of communications strategies to maintain a unified message and avoid repeating these negative public optics. Cracks that were identified during the last pandemic can be filled, and the communication infrastructure strengthened.

"The pandemic revealed and exacerbated existing vulnerabilities in Maryland's public health infrastructure, including workforce gaps and shortages, administrative hurdles, insufficient funding for maintaining a strong public health infrastructure, and the antiquated nature of many of our data systems."

The pandemic revealed and exacerbated existing vulnerabilities in Maryland's public health infrastructure, including workforce gaps and shortages, administrative hurdles, insufficient funding for maintaining a strong public health infrastructure, and the antiquated nature of many of our data systems. What became clear is that our foundational public health capabilities were not working as optimally as they could to prevent and address not just infectious diseases, but all health conditions, including chronic diseases, cancer, maternal health, mental health disorders, and addiction. Importantly, our ability to close health disparities is hampered by these realities.

The proliferation of inaccurate information led to increasing public mistrust in science. The pandemic underscored the critical value of local community ambassadors and trusted messengers to gain buy-in with respect to health-related communications. Effectively translating scientific evidence into information and solutions that will be accepted by the community remains a challenge.

Overdoses

Efforts are underway to respond to the overdose crisis. By executive order, Maryland Gov. Wes Moore moved the Opioid Operational Command Center into MDH, renaming it Maryland's Office of Overdose Response to broaden the state's efforts to combat the opioid and drug overdose crisis.

Technological advances have helped disseminate information related to overdose statistics. The Maryland Overdose Dashboard has facilitated efforts to disseminate information about the trends in overdoses and variation by demographic characteristics, and as such, has illuminated health disparities.

Further refinements to our information technology infrastructure are required to track Narcan distribution across the public health and healthcare delivery systems.

There are serious workforce shortages in the field of addiction medicine and behavioral health. Like other workforce shortages, these shortages are particularly pronounced in the rural areas of the state.

Evidence-based substance use prevention and early intervention strategies need to be expanded. In most cases, overdoses represent a very late-stage consequence of a long history of substance use involvement. Identifying individuals at earlier stages of substance use involvement requires incorporating standardized assessments into primary care and health centers in educational settings. In that way, substance use involvement can be treated as a health issue. Behavioral health disorders were a frequent issue of concern mentioned in public comments. There were personal stories and pleas for more proactive strategies to deter use, including addressing the root causes.

Maternal and Infant Mortality

Policies and programs in Maryland have improved the health of mothers and infants. Despite challenges such as underfunding, there are exemplary models to address and promote the health of mothers, such as the Babies Born Healthy (BBH) program[31] and the Baltimore City B'more for Healthy Babies (BHB) program.[32] The BBH program is funded by Title V and is a perinatal care coordination program addressing disparities in infant mortality rates in Maryland. The BHB program is an initiative to reduce infant mortality in Baltimore City through programs emphasizing policy change, service improvements, community mobilization, and behavior change. Additionally, the Healthy Babies Equity Act of 2022 was cited as a key success in expanding coverage for pregnant women to reduce disparities in certain populations.

> **"Funding for program evaluation would illustrate program impact and benefit efforts to secure future funding."**

However, additional resources are needed to expand these underfunded programs, and there is a general sense of a lack of investment in maternal and child health efforts. LHDs are tasked with doing "what we can for little money." For example, some counties expressed interest in the ability to support doulas and doula services and noted the inability to do so with current funds. Smaller counties are not eligible for some programming due to grants being determined by the size of the population served. Funding for program evaluation would illustrate program impact and benefit efforts to secure future funding.

The State Health Improvement Plan (SHIP) has set goals for 2029 to:

- Reduce the rate of preterm births from 10.7% to 9.4%
- Reduce the infant mortality rate from 6.5 per 1,000 live births to 5.2 per 1,000 live births
- Reduce the percentage of babies born with low birth weight from 8.5%
- Reduce the total maternal mortality rate from 21.7 to 17.2 per 100,000 live births, and for Black women from 30.7 to 19.2 per 100,000 live births
- Increase the percentage of pregnant women who receive prenatal care beginning in the first trimester from 78.1% to 82%[33]

Increased focus on specific populations is central to reducing maternal and infant mortality. Certain populations are disproportionately impacted by maternal and infant mortality. According to the SHIP, Black Marylanders experience maternal mortality at a rate that is 60% higher than white Marylanders. Multiple factors drive this excess burden, including lack of access to healthcare, chronic health conditions, lack of transportation, poverty, food insecurity, structural racism, and mistrust in the healthcare system due to historical poor and unethical treatment of communities of color. A lack of local and culturally appropriate providers and a lack of transportation were identified as two main contributors to the lack of access to care. Solutions such as rideshare services do not fully solve gaps in public transportation, as these are often not eligible for contracting and reimbursement from the LHDs. Social determinants of health significantly impact the ability to address maternal and infant mortality.

Reductions in maternal and infant mortality require building trust with communities and developing community partnerships. Collaboration with a wide range of partners is key, including those from public health and the healthcare system, government officials, faith-based organizations, nonprofits, substance misuse and abuse networks, policymakers, and trusted community leaders. For example, LHDs often rely on partners to facilitate community needs assessments to identify communities that are experiencing adverse birth outcomes. To be truly impactful with partners, information and data must be communicated in clear and accessible terms and respectfully contextualized with lived experiences.

Linked assessment and data surveillance systems would facilitate the prevention and care of these conditions. Available data related to maternal and infant mortality are often incomplete. Factors driving maternal and infant mortality occur along the continuum of women's health (i.e., adult care, obstetric care and delivery, and post-partum and pediatric care). LHDs expressed a need for standardized screening tools for the social determinants of health that impact maternal outcomes. An integrated data system that included information on social determinants of health, demographics, healthcare access, prenatal care details such as risk factors and complications, birth outcomes, and postpartum outcomes, including mortality data, would improve identification of high-risk populations, hopefully improve maternal health outcomes, and allow for more thorough analysis of the efficacy of upstream policy interventions.[34]

SECTION 3

The Ask

THE COMMISSION'S RECOMMENDATIONS

SELECTION AND ORGANIZATION

The Commission's work has culminated in a set of recommendations—proposed actions that, if implemented, would strengthen and "improve the delivery of foundational public health services in the State" and allow the state's public health system to achieve its full potential. These recommendations are informed by the extensive scan of the health, social, economic, and political environment; learnings from peer states; local and national public health experts; the critical review of the workgroups; Assessment Team findings; and public comments.

On June 9, 2025, the Commission published the initial recommendations from the workgroups for public review on the Commission's website, where individuals could electronically submit their feedback. These draft recommendations varied in specificity and construction, with the intention of further refining them in later drafts and after receiving public feedback.

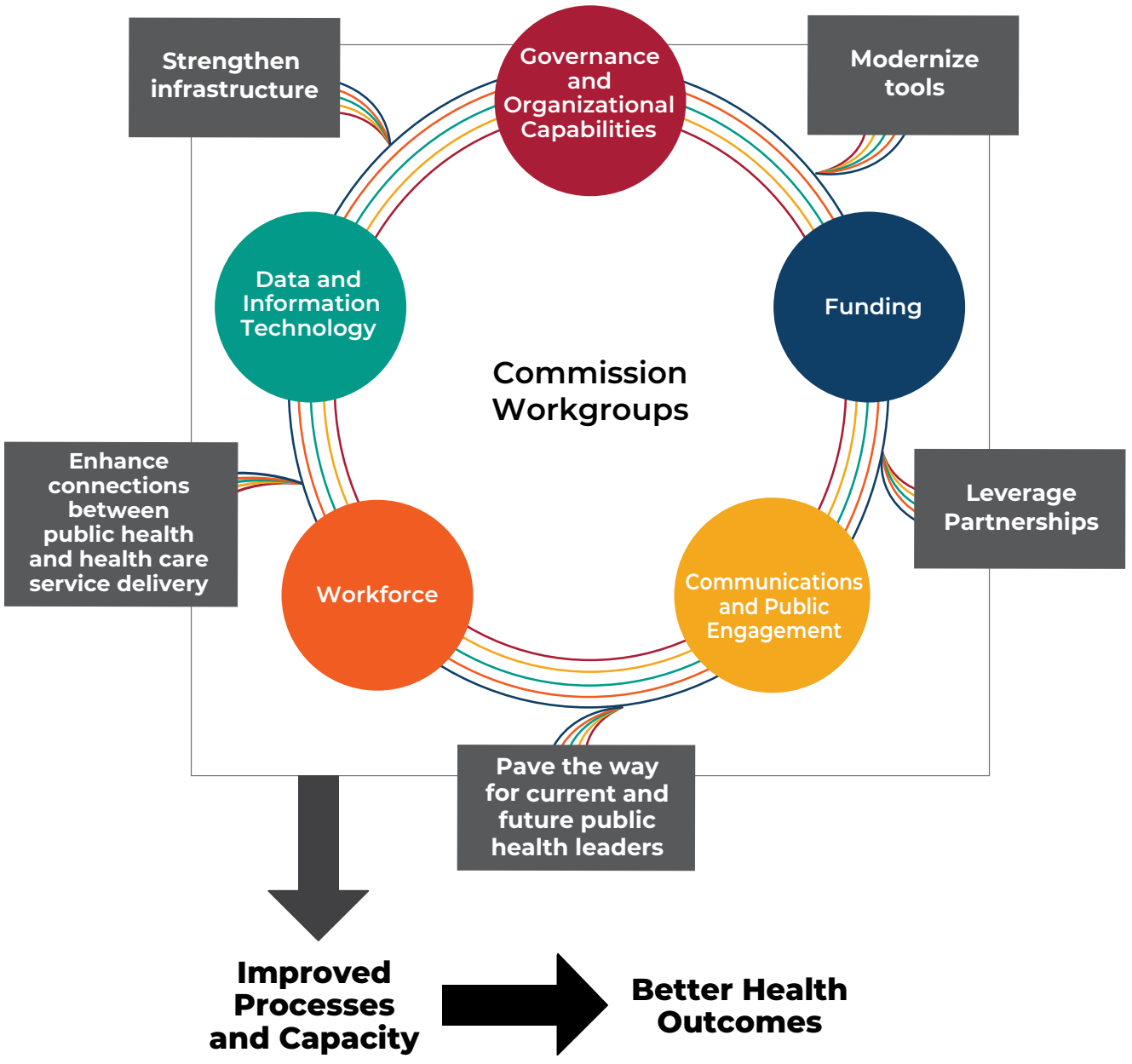
Once the Commission received the public feedback, it met to determine which feedback to incorporate into the recommendations, whether additional recommendations would be added to the slate, or whether any feedback would be precluded from consideration. This section presents the slate of recommendations.

To organize the feedback, the Commission used the following hierarchy:
Themes, Strategic Objectives, and Recommendations.
Five Recommendation Themes emerged, each with Strategic Objectives, resulting in specific recommendations or calls to action.

FIGURE 12: HOW THE COMMISSION TRANSLATED ITS FINDINGS INTO RECOMMENDATIONS

These recommendations have been organized to address five major themes—broad topic areas that summarize key focus areas for action. The themes are further delineated by strategic objectives. Each strategic objective is followed by targeted actionable recommendations. Each goal is followed by targeted actionable recommendations. Recommendations may be policy-related, administrative, or legislative in nature. Recommendations have an ID associated with them to allow for cross-referencing.

FIGURE 13. LINK BETWEEN WORKGROUP ACTIVITIES AND RECOMMENDATION THEMES



THEMES AND STRATEGIC OBJECTIVES

1. Strengthen Public Health Infrastructure

▸ **Leadership and Governance**

- Realize benefits of Maryland's Governance structure
- Align governmental public health activities
- Create equity impact assessment policies
- Enhance internal communications

▸ **Human Resources**

- Upgrade the human resource system
- Protect the existing workforce
- Establish innovative teams

▸ **Funding**

- Review existing funding mechanisms
- Explore new funding models
- Dedicate new funding to these critical areas: health communication, technology, and health needs assessments

2. Modernize and Maximize Communication, Data, and Information Technology Tools

- Bolster public engagement
- Activate health-related communication
- Streamline IT operations
- Enhance health-related data collection, management, and analysis capabilities

3. Leverage and Formalize Partnerships

- Coordinate with other governmental agencies
- Partner with academic institutions
- Heighten partnerships with statewide non-profit health organizations
- Strengthen connections with healthcare organizations
- Build stronger relationships with the private sector

4. Bridge Between Public Health and Health Care Service Delivery

- Enhance connections between public health, primary care, and health care delivery systems
- Clarify public health capacities for the legislature and the public

5. Pave the Way for Current and Future Public Health Leaders

- Invest in public health workforce development, policy, and planning
- Design and develop innovative educational and service offerings

About two-thirds of the recommendations (Themes 1 and 2) directly address the legislative charge and propose actions to support and strengthen governmental public health operations and capabilities to better serve Maryland's public health areas, which are the goals of the 2024 State Health Improvement Plan and findings of the State Health Assessment. Essential to the strengthening of our infrastructure is modernizing our systems for health communication and information technology so that we can better engage the public and make better-informed decisions. An additional grouping within the Theme 1: *Strengthen Public Health Infrastructure* theme highlights the interdependence between strategic objectives that address the key functions of *Governance*, *People*, and *Funding*.

The recommendations located in Themes 3 and 4 speak to critical components of our state's public health system, formalizing collaborations with partners and alliances across the public health to healthcare delivery continuum to achieve overall health and well-being for all Maryland residents. Theme 5 calls for a strategic approach to ensure that the current workforce is given optimal opportunity for professional advancement and that we create excitement in our young people to pursue future public health careers.

The Commission offers these recommendations with full awareness of the current economic and political climate and the continued challenges to the public's health and to our public health system. The Commission had the privilege to learn about the strengths and needs of the state's public health capabilities, witness innovative approaches to public health activities and services, and listen to visionary ideas about how to achieve a stronger system aligned with the partners and healthcare. With respect to careful input and deliberations, these recommendations range from basic to aspirational. It is anticipated that with time, they can all be addressed given Maryland's deep commitment to the health and well-being of all residents and its innovative spirit to address public health needs. The recommendations are interrelated and interdependent. The challenges we have in front of us are not simple nor easy to solve. But they are addressable, with a clear vision, optimism, and perseverance. Maryland is well-poised to lead the nation in its thinking and in its actions around these urgent health issues.

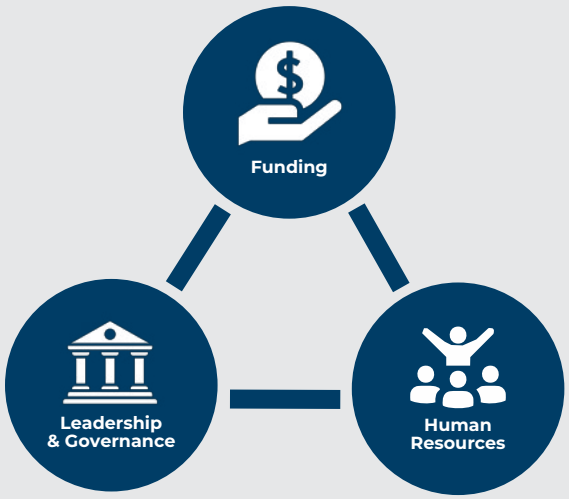
"The Commission offers these recommendations with full awareness of the current economic and political climate and the continued challenges to the public's health and to our public health system."

The terms Maryland Department of Health (MDH), local health department (LHD), and local health officer (LHO) are used throughout.

= Objective >>> = Recommendation

THEME 1. Strengthen Public Health Infrastructure

The recommendations in this section are related to three core elements of Maryland's public health infrastructure: 1) Leadership and Governance; 2) Human Resources; and 3) Funding.



Refinement of Maryland's public health infrastructure builds on our existing strengths and our commitment to shared governance. Effective shared governance is highly dependent on collaboration with other government agencies that have critical roles for public health, an efficient human resources system, and adequate funding. Moreover, continuous measurement of outcomes is required to ensure that we are moving toward the goal of health equity throughout the systems that are involved in public health and clinical services. The capacity of the entire public health system will benefit from coordinated leadership, improved administrative operational capacity, statewide and mutual accountability metrics, shared decision-making structures, and collaborative oversight.

LEADERSHIP AND GOVERNANCE

Realize Benefits of Maryland's Governance Structure

The Commission affirms its support for shared governance of the public health system that empowers state and local public health officials to collaborate and function interdependently to help Marylanders achieve their optimal health and wellness. This model recognizes the role of the state in coordinating and promoting macro-level strategies across jurisdictions while vesting authority and autonomy with LHOs to function as chief health strategists within their communities. Shared governance recognizes the best interests and diverse needs of Maryland's communities across and within Maryland's 24 jurisdictions. Effective shared governance is only possible in the context of smooth and state-of-the-art administrative operations, an efficient human resources system, and adequate funding.

The following recommendations to refine our public health infrastructure build on our existing strengths. Continued collaboration with other government agencies that have critical roles in public health will be required. Moreover, continuous measurement of outcomes is required to ensure that we are moving toward the goal of health equity throughout the public health and clinical health systems. The capacity of the entire public health system will benefit from coordinated leadership, statewide and mutual accountability metrics, collaborative oversight, and shared decision-making structures.

»» Shared Governance Support

Strengthen and enhance shared governance to provide for more definition and mutual understanding between state and local partners on how best to coordinate public health planning, implementation, and evaluation of foundational and essential public health services.

This model further reinforces the principle that each partner is operating with the best interests of their constituents in mind and collaboratively working with key partner state and local agencies. **(ID: GOC-052)**

»» Co-Creation Framework Model

Maximize effective administrative and clinical public health service planning and delivery, health monitoring, and policy development through using a co-creation framework at the state and local level. This will require collaboration and integration of local health officer experience and knowledge in the development of policy positions and policy making using Maryland Department of Health's Roundtable meeting between the Public Health Services Administration and local health officers. It is also recommended that a framework for policy development and implementation be developed and implemented through consistent and equitable collaboration between state and local health departments while ensuring alignment with state laws and flexibility for local needs.

This promotes coordinated systemwide data-informed planning and evaluation; strengthens system capacity through coordinated leadership and shared decision-making structures; promotes collective impact; and enhances performance management by establishing statewide and mutual accountability metrics and collaborative oversight. The Maryland State Health Improvement Plan and State Health Assessment are examples that benefit from the co-creation framework. **(ID: GOC-011)**

Align Governmental Public Health Activities

Maryland's public health system interacts with many other governmental entities. Therefore, the following recommendations call for a stronger alignment of public health-related goals and coordination of the activities among administrations, commissions, and departments that are essential to the state's health, healthcare, and well-being programs.

Having an agreed-upon set of shared health outcome metrics would support effective public health alignment among governmental entities. As an example, Maryland's long-standing commitment to improved healthcare delivery and the Total Cost of Care, led by HSCRC, is reflected in its continued efforts to create a more efficient value-based healthcare delivery model. This model emphasizes population health and integrates primary care, building on the Maryland Primary Care Program learnings, and behavioral health. The Achieving Healthcare Efficiency through Accountable Design (AHEAD) model will be implemented from 2026 through 2034 and shared metrics could ensure coordinated efforts. Additional related issues are addressed in Theme 3 and Theme 4.

MDH is a "super-agency"—it oversees multiple related large programs in addition to public health services. Behavioral health, located in MDH's Behavioral Health Administration, was an area highlighted by the Commission that would benefit from improved coordination and collaboration. While MDH houses both the

Behavioral Health Administration and Public Health Services Administration, challenges exist related to case and community health management for behavioral health services. Viewing these services as primary care safety net programs could lead to benefits (e.g., early intervention, decreased need for costly crisis management). In local jurisdictions, Local Behavioral Health Authorities (LBHAs) receive funding from the MDH Behavioral Health Administration, including behavioral health activities related to primary and secondary prevention. While many LBHAs are units within their LHDs, some exist outside the LHDs. In some jurisdictions, part of the LBHA role (mental health or substance use related) may be within the LHD while the other may exist outside the LHD.

Public health surge capacity for emergencies and other crises is of critical importance. While the Maryland Department of Emergency Management (MDEM) has an important and statutorily defined role of coordinating responses to emergencies and disasters, often public health agencies have specific responsibilities locally or at the state level in this coordinated response. Additionally, public health agencies sometimes address community situations, such as emerging outbreaks, before activating their local or state emergency operations centers. Thus, public health agencies need to surge their workforce and response capacity to fulfill public health responsibilities demanded during sector-specific or cross-sector emergencies. The existing public health emergency preparedness programs at state and local levels, as well as the Maryland Medical Response Corps, exist because of these public health responsibilities and surge needs. Implementing the following recommendations will help ensure an even more robust response to public health surge needs and emergencies.

»» Set of Shared Health Outcome Metrics

Create shared health and healthcare outcome metrics and goals to facilitate public health and healthcare services alignment and innovation and to jointly monitor progress. (ID: PCP-068)

»» Public Health Foundational and Behavioral Health Services

Examine the different functions performed by Local Behavioral Health Authorities (LBHAs) and better allocate those functions to ensure that communities are getting the best integrated services.

Preventive and early intervention services, such as suicide prevention education, harm reduction, and data mapping, are core public health work and should be integrated into LHDs in jurisdictions where this is not already the case. These services are analogous to other core public health services provided by LHDs and would allow better integration and greater efficiency across the public health continuum at a local level. The oversight and regulatory functions can operate through either LHDs with integrated LBHAs or via separate LBHAs, but a more consistent mechanism reduces complexity in the system and allows for greater efficiency with public dollar services. **(ID: CCR-064)**

»» Local Public Health Surge Volunteer Pipeline

Appoint a Public Health Surge Facilitator by MDH to assist each local health department in building their public health surge capacity.

This individual would work with both the state's MRC coordinator and local health officers to support local-level efforts in recruiting and training local volunteers in public health capabilities. These volunteers will be encouraged to join MRC so that they can be officially deployed when there is a public health surge need. State level assistance can help LHDs attract and retain volunteers with communications, technology including learning management systems, and training. This will enhance both the pathway into MRC as well as the pipeline into a public health employed

workforce. When necessary, the facilitator could support the MRC Coordinator in optimizing distribution of public health human resources during an emergency. **(ID: WKF-053)**

»» Maryland Responds Medical Reserve Corps Expansion

Expand and enhance local engagement for the existing Maryland Responds Medical Reserve Corps.

This will require: (1) Renaming it to the "Maryland Responds Health Reserve Corps" and explicitly recruiting non-clinical personnel capable of assisting during public health emergencies, disease outbreaks, natural disasters, and other crises that strain the healthcare and public health systems; (2) Supporting more robust, locally focused and trained jurisdictional volunteer corps; (3) Ensuring dedicated funding for coordinators to work in local jurisdictions; and (4) Modernize and make more efficient the state's electronic registration system which documents and tracks volunteers. The legislature should allocate dedicated resources for this expansion and fund LHDs to recruit needed non-clinical personnel, build a more robust, locally focused and trained county-based volunteer corps, and ensure emergency public health response readiness. **(ID: WKF-014)**

»» Environmental Health System

Identify and procure an environmental health system to be used by the Maryland Department of the Environment, MDH, and LHDs to improve efficiency of permitting for state and local agencies, and the general public.

This will create improved accountability, increased constituent satisfaction, and ideally attract more business to the state and local jurisdictions. While ideally incorporated into a universal electronic health record (EHR), Environmental Health poses unique challenges, including permit capture and online payments, public input, and tracking of licensure, complaints, investigations, and other unique functions. Additionally, this system would allow for improved reporting and analysis. Development of a system should maintain interoperability with local county systems and be informed by local input. **(ID: DIT-050)**

Create Equity Impact Assessment Policies

Building on Maryland's years of effort to address social drivers of health, assessing equity during the policy development process will help identify disparities earlier. These recommendations operationalize the equity lens across sectors and governance levels and align with Maryland's focus on health equity (e.g., Maryland's Payment Model and the State Health Improvement Plan). Additionally, the recommendations acknowledge that each branch of government has a role to play in addressing systemic and long-standing challenges and disparities.

»» Equity Impact Assessment Policy for the Executive Branch

Establish and operationalize in State Government an Equity Impact Assessment policy to ensure health equity are central to the development, implementation, and evaluation of the promulgation and removal of regulations by Social Determinants of Health-related agencies to be defined by the Secretary of MDH when circumstances or thresholds determined by those agencies are met. **(ID: GOC-061)**

>>> Equity Impact Assessment Policy for the General Assembly

Establish and operationalize in the Maryland General Assembly an Equity Impact Assessment policy to ensure health equity are central to the development, implementation, and evaluation of proposed legislation. (ID: GOC-062)

Enhance Internal Communications and Support

The Commission's work revealed a need to strengthen internal communications within MDH and give visibility to public health initiatives within MDH. There was also interest in enhancing communications between LHDs to support ongoing collaborations, sharing successes, and building support for formal LHD accreditation where it does not exist now.

>>> MDH Public Health Grand Rounds Series

Develop a MDH Public Health Grand Rounds Series to be a forum for horizontal communication across MDH departments that would allow sharing of successes of public health initiatives and successes in implementation.

A Grand Rounds Series could provide a way to come together regularly around an important topic of shared interest. Invited participants could include LHDs, primary care clinicians, academicians, professional associations, elected officials, and community partners. **(ID: GOC-043)**

>>> LHD Accreditation

Facilitate the accreditation or Pathways Recognition status of interested LHDs by the Public Health Accreditation Board (PHAB) or other similar accreditation and pay the annual fees (MDH responsibility).

Being accredited or designated as Pathways Recognized would inform local health officers and their staff of major areas to address to support quality improvement of services and operations. It also will provide a high level of assurance to the communities they serve by instilling a culture of quality improvement and excellence. **(ID: GOC-057)**

>>> Listserv for LHDs

Establish and maintain a LHD listserv for specific roles within LHDs.

This would facilitate communication amongst LHDs, provide an opportunity to share resources and announcements, enhance communication between MDH and LHDs, and stimulate cross-jurisdictional collaboration. Ensure a routine check system and a point person for regularly updating listservs with correct contacts. (MDH/MACHO leads) **(ID: GOC-044)**

HUMAN RESOURCES

Our personnel and staff are our most valued asset and comprise the majority of governmental public health's operating funds. The following recommendations call for efficient and equitable processes for the timely recruitment, support, retention, and promotion of individuals and teams. The rapid evolution and complexity of public health work necessitate flexibility in these processes to equip individuals and teams with new skills and technologies and to address ever-changing public health challenges.

Upgrade the Human Resource System

Maryland's personnel system must be transformed from a persistent barrier to public health services delivery to a strategic asset. An initial step is to enable full access to job classifications, a no-cost, high-impact policy change that will help modernize the public health workforce, promote equity across jurisdictions, and ensure that local health departments are no longer boxed into outdated or inappropriate human resource processes that are not efficient or aligned with current needs.

A dedicated human resources classification system is essential to help modernize Maryland's public health infrastructure, professionalize the field, and build the resilient, responsive workforce the state needs now and in the future. It ensures that job requirements and duties are aligned to the specific needs of public health without interfering with generic or broad classifications that other agencies use. The following recommendations aim to reduce duplication and better utilize the personnel system so that senior public health leaders can recruit and retain the needed workforce and be responsive and adaptable to the concerns of their respective communities.

>>> State Personnel System Task Force Recommendations

Prioritize the timely and full implementation of the recommendations outlined in the 2023 State Personnel System Task Force report.[35] (ID: WKF-039)

>>> Access to Complete State Personnel Job Classifications

Grant LHDs full access to the complete range of job classifications within the state personnel system, including higher-grade classifications commonly used in other state health agencies. (ID: WKF-037)

>>> Distinct MDH/LHD Job Classification Options

Establish a set of distinct job classification options tailored specifically to the needs of the MDH and LHD workforce. (ID: WKF-038)

>>> Study/Commission on Public Health Human Resources Reform

Authorize a comprehensive study or Commission on Human Resources Reform to strengthen LHO autonomy and explore the option of an independent human resources system for MDH, modeled on agencies like the Maryland Department of Transportation. (ID: WKF-040)

Protect the Existing Workforce

Essential to public health workers, and even all government workers, is the creation of an environment that is safe and protects them from harm. In addition, the need for state-level leadership for personnel, such as public health nurses, guards this highly prominent public health workforce component.

>>> Legal Protection of Public Health Employees

Enact legislation to protect all state and local public health employees and contractors by establishing or strengthening penalties for individuals who threaten, harass, intimidate, stalk, assault, or otherwise interfere with public health workers during their official duties. (ID: WKF-015)

>>> Statewide Chief Nurse Officer

Appoint a Statewide Chief Nursing Officer to provide technical assistance specific to nursing across Maryland.

Nurses comprise a significant percentage of the public health workforce. This role can focus on the more than 1,000 nurses within LHDs, such as continuing education, development of policies or revising job classifications. The critical role of nurses in the leadership and delivery of public health services cannot be underestimated. **(ID: WKF-054)**

Establish Innovative Teams

To optimize coordination, collaboration, and responsiveness of the shared governance model, recommendations are made to establish teams of individuals to expedite technical assistance; assist with proposal development and grants management; and support planning, implementation, and assessment of foundational public health services. In order to function most effectively, LHDs need direct and frequent interface with all MDH deputy secretaries and leaders of multiple units within MDH, not just those within the Public Health Services Administration.

>>> Bureau of Local Health Department Assistance and Support

Authorize the creation of a Bureau of Local Health Department (LHD) Assistance and Support in the MDH Office of the Secretary.

This bureau will strengthen coordination across LHDs and to serve as a technical assistance body for the state's 24 local health departments, utilizing MACHO as a liaison. This bureau would not direct or oversee local operations but would facilitate cross-jurisdictional collaboration, elevate common challenges, and promote consistency in public health practice where appropriate. **(ID: WKF-041)**

»» MDH Grant Team

Establish a more robust MDH grant team that searches for grant opportunities for both the state and local levels and includes representatives from small and large local health departments.

A collaborative team can more efficiently identify grant opportunities that match with statewide public health planning and avoid duplication of efforts that would inevitably occur with 24 different jurisdictions trying to find new grants. An MDH-led team would also be able to coordinate with other state agencies (e.g., Departments of Environment, Aging, Housing, Transportation, and more) to apply for grants that go beyond traditional health boundaries. **(ID: FND-022)**

»» Public Health Resource Team

Establish a Public Health Resource Team, involving the new hires of 10-12 MDH staff level positions to execute the Commission on Public Health's recommendations and other related recommendations, monitor the success of changes made to the system as a result, and broker partnerships with public and private entities to leverage their expertise in developing solutions.

This panel of experts/strike team can assist LHDs and MDH with emerging public health issues, public health crises, and policy development. Moreover, they could be instrumental in designing and implementing large cross-cutting public health initiatives by leveraging multiple governmental state agencies and external partners. **(ID: GOC-042)**

FUNDING

Federal funding for public health activities is under threat in unprecedented ways. As a state, we must carefully understand the impacts of these challenges on basic public health services and prepare for both the continuing and emerging threats that can compromise the health and quality of life of Marylanders. The following recommendations call for a review of existing mechanisms and exploration of new funding models and sources. The recommendations also highlight the urgency for new funding in critical areas of health communication, technology, and health needs assessments, which the Commission identified to be foundational to strengthening our public health infrastructure.

Review Existing Funding Mechanisms

»» Core Funding Model Assessment

Conduct an in-depth assessment of the core funding model to ensure it adequately and equitably serves current public health needs and changing demographics since its formation in the 1990s.

The proportional allocation to each local health jurisdiction, percentage of local-state match for each jurisdiction, categories of public health activities eligible to receive core funds, and any other areas will benefit from updating. The assessment will include examination of county-level funding models, service delivery activities, and the capacity to fulfill foundational public health services, and the identification of successful models that can be used to inform a new funding model. The assessment will include the input of LHDs to allow more flexibility by county and provide all-party access to the formula for full understanding and transparency across the governmental system, while maintaining MDH control over allocations. ***(ID: FND-054)***

»» Procurement and Contracting Efficiencies

Invest in better processes and technology systems to enhance procurement, contracting efficiencies, and contract monitoring among MDH and LHDs and hire dedicated personnel and procurement personnel to streamline processes, reduce delays, acquire resources efficiently, and monitor expenditures to support critical public health programs. *(c.f. DIT-049).*

This recommendation will make better use of existing funding by streamlining and redesigning the procurement and contracting process. **(ID: PCP-070)**

»» Grant Flexibility

Join national organizations to advocate for federal grants with longer duration and more local flexibility to better address underlying complex health factors at local and state levels.

There is a critical need for more "flexibility with accountability" in the utilization of federal funds through grants and contracts. **(ID: FND-007)**

Explore New Funding Models

With the continued demands of the public's health needs and growing opportunities to administer evidence-based health promotion and disease prevention programs, it is important to be alert and explore new funding approaches. The Commission supports ongoing critical reviews of existing and potential public and private sector funding opportunities to support public health and the development of ways to incentivize efficiencies, cost-savings, and collaborations focused on health improvement.

»» Medicaid Reimbursement Taskforce

Establish a Medicaid Reimbursement Taskforce to be convened by MACHO.

The taskforce will have representatives from MDH Healthcare Financing/Medicaid, MDH Public Health Administration, LHOs, LHD billing professionals, and MACo (Maryland Association of Counties). The taskforce is charged with collaboratively working on the following issues, in addition to other items that are determined by a majority vote to be germane. A progress report and potential legislative fixes will be submitted annually to the chairs of Maryland General Assembly House Health and Government Operations and Senate Finance Committees.

- *Studying ways to streamline and simplify Local Health Department contracting process for insurance carriers and governmental (including master agreement negotiation, issuing normative guidance, or adopting legislation requiring carriers to enroll and credential LHDs) and making recommendations to the MDH Secretary.*
- *Studying the feasibility of restructuring Medicaid reimbursement rates for LHDs in a way that is analogous to FQHC reimbursement to better reflect the payer mix of public health agencies cost of services provided and account for the complex population needs.*
- *Exploring ways that LHDs can share in cost savings that produce measurable reductions in Medicaid expenditures as a direct result of successful public health programs. For example, reducing neonatal intensive care unit costs to Medicaid as a direct result of improved outcomes for high-risk pregnancies.* **(ID: PCP-071)**

>>> Health-Related Funds

Savings from the healthcare financing and delivery system should be reinvested into a fund to advance prevention, population health, and public health.

Supported strategies should be informed by input from a variety of public health stakeholders, including public health agencies, professional clinician associations, and community organizations. LHOs as chief health strategists should be leveraged for steering implementation in their jurisdictions. **(ID: CCR-063)**

>>> Charitable Foundations

Pursue strategies to identify funding from charitable foundations (coordinated by MDH, LHDs, and the Governor's Office).

Public health initiatives have natural alignment with the goals of many charitable foundations and foundation grants steered by health departments may be vital to advancing community health in Maryland. **(ID: FND-021)**

Dedicate New Funding to Three Critical Areas: Health Communication, Technology and Health Needs Assessments

>>> Health Communications Development and Dissemination

Prioritize existing funding or allocate additional funding, to promote the development and dissemination of health communications materials to the public.

This should enhance public health agency communication capacity, foster engagement with the public, and reduce rumors and misinformation. Public health agencies should collaborate with partner organizations, such as associations of primary care clinicians, to increase the reach of important public health messaging to specific target audiences. **(ID: CPE-020)**

>>> Information Technology Funding

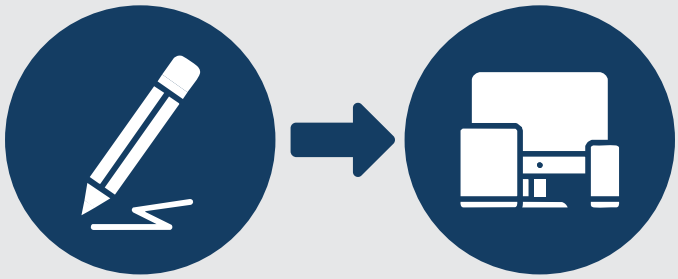
Create a separate mechanism for annual funding of technology (outside of LHD core funding) that supports the current and emerging technology needs for public health at the state and local level (MDH and LHDs). **(ID: DIT-052)**

>>> Community Health Needs Assessment Support for LHDs

Secure necessary resources for LHDs to effectively complete and use data from Community Health Needs Assessments (CHNAs) by dedicating full-time staff and support for collaboration with local hospitals, school-based health centers, or community health centers, and thus reduce duplication of efforts, align priorities, and improve implementation of community health strategies. **(ID: CPE-018)**

THEME 2. Modernize and Maximize Public Engagement, Communication, Data, and Information Technology Tools

Antiquated systems are pervasive throughout Maryland's public health infrastructure. Communication and engagement with the public is often hampered by the lack of support for modern communication strategies and state-of-the art technologies. Existing expertise in Maryland related to communications and information technology must be better leveraged. The following recommendations are necessary to engage the public more broadly, equitably, and regularly.



The Commission's work underscored the need to modernize our data systems at all levels. The goal to make data-driven decisions the norm, rather than the exception, will require a transformation of how data is used, analyzed, and translated into actions to improve the health of Marylanders.

Bolster Public Engagement

Throughout its process, the Commission learned the value of public feedback and engagement. Similarly, community health assessments, community health improvement processes, and local health improvement coalitions reveal the essential role public input plays in identifying community needs, developing realistic plans, and securing collaborative involvement and success. Listening sessions, focus groups, and town meetings are some of the ways Maryland can foster public engagement. In addition, Maryland can enhance community trust using local influencers and public spaces to deliver relevant, culturally tailored messages.

>>> Visibility of Public Health

Develop a communications initiative such as a "Maryland Public Health Issue of the Month" series run by MDH in collaboration with LHDs and academic partners to enhance the visibility of the valuable public health work going on at the local level, clarify the scientific evidence around a timely public health topic, or call attention to an emerging issue or outbreak.

Highlight and engage experts who may be from additional sectors, such as local and national professional associations, nonprofit organizations, volunteers, academia, public agencies, and other countries. Leverage existing efforts, such as the national Public Health Communications Collaborative, and collaborate with key partner organizations, such as MACHO and associations of primary care clinicians. **(ID: CPE-045)**

»» Public Feedback

Provide funding to support concerted and documented public feedback on public health information, programs, and services, and to ensure that health departments engage in ongoing, bi-directional feedback with the public.

This recommendation provides support for a stable messaging system that would include feedback loops to evaluate to what extent public health messages, programs, and services reach intended audiences and how feedback can continuously improve public access to these activities. **(ID: CPE-003)**

»» Central Community Portal

Create a central community portal designed for use by the public to include interactive, downloadable dashboards, tools for community engagement with a data collection function, and education with a focus on Maryland-specific data sets and incorporating plain language terms to remain accessible to the public.

Work alongside existing resources like the Consumer Health Information Hub. **(ID: DIT-053)**

Activate Health Related Communication

Clear communication with the public is essential because they need to know about and understand a wide range of topics for their personal and community health decisions. These recommendations will increase the likelihood that the public will understand and use public health information, programs, services, and recommendations for their health benefit. The Commission emphasizes the importance of investments at the local county level, anchored by a public information officer and team, and building LHD capacity where trust and personal relationships with the community are strongest. The Commission also recognizes the value of shared resources such as language access and plain language support.

»» LHD Public Information Officer Leadership

Appoint a full-time dedicated public information officer (PIO) for each LHD to ensure that communities are informed and prepared to understand and act on public health information, programs, and services. **(ID: CPE-004)**

»» Language Access Support

Provide new and dedicated funding for public agencies, especially MDH and LHDs, to support dedicated translation and interpretation services, including languages other than Spanish, and to increase bilingual/multilingual staff in health departments to ensure that all public information shared by Maryland state and local agencies are in accordance with Maryland laws and executive orders on language access.

Currently, Maryland provides a blanket contract mechanism for public agencies to streamline procurement of these services, but each agency must identify its own funds. **(ID: CPE-002)**

»» Plain Language Support

Provide funding to support dedicated access to plain language experts and contracts for public agencies, especially the MDH and LHDs, to ensure that all public information shared by Maryland state and local agencies uses plain language in accordance with Maryland laws and executive orders.

This recommendation builds on Maryland's commitment to plain language support (HB1082), Maryland's Consumer Health Information Hub directed by the Horowitz Center for Health Literacy[36], and Maryland's Executive Order on Plain Language.[37] **(ID: CPE-001)**

»» Health Communication Tools Modernization

Utilize all available and relevant communication methods, tools, and partnerships to ensure health departments are meeting community needs and promoting modernization and expansion of health communications messages.

Updating and modernizing health communication tools could improve communication reach and accessibility through modern tools like SMS alerts, chatbots, and interactive portals for timely, multilingual communication. **(ID: CPE-005)**

Streamline IT Operations

The Commission identified inherent problems with existing systems and processes—leading to internal communication problems, lack of efficiency, and limited interoperability of governmental public health and related systems in the state. As a result, information is sometimes incomplete for planning and evaluation. Streamlining operations will improve the ability to collect, access, link, analyze, interpret, and use data. Data originates from a variety of sources, including granular data, and can be disaggregated by geography (e.g., census tract, zip code), sub-populations, race, ethnicity, and other variables that fully describe the health and well-being of a community and the factors that influence health. These recommendations aim to increase the capacity to collect timely and sufficient foundational data to guide public health planning and decision making at the state and local level, including the personnel and technology that enable collection and utilization.

Improving business functions will be critical to ensure compliance with federal, state, and local standards, policies, and procurement processes; required grant award management and oversight; and maintenance of facilities and efficient operations. Achieving consistency in business systems across LHDs will facilitate effective collaborations among health departments. Fast-developing technology and increasingly complex public health issues necessitate ongoing modernization of public health data systems. While recommendations may be made centrally, implementation decisions and processes should be steered by local needs and the people closest to public health action.

»» Commission on Data and Information Systems Modernization

Establish a standing commission of public (including MDH, LHDs, Maryland Department of IT [DoIT], and CRISP) and private partners to identify opportunities and strategies for ongoing modernization of public health data and information systems.

The commission could consider evolving technologies such as Artificial Intelligence (AI) and make recommendations for the state's public health system to improve efficiency, support flexibility, and ensure security and effectiveness. **(ID: DIT-046)**

»» Five Year Enterprise Data and IT System Plan

Design and implement a 5-year enterprise data and information technology (IT) system architecture plan (or "Roadmap") for state and local health departments to ensure a coordinated strategy that creates funding and resource predictability, and improves planning as well as system awareness, transparency, and constituent buy-in.

This plan should build in flexibility and check points to pivot to market and technology changes. **(ID: DIT-051)**

»» Efficiency of Business Functions

Assess and implement streamlined technology platforms and databases to improve the efficiency of health department business functions, such as budgeting/finance, accounts receivable, human resources, procurement, medical billing, and grants management.

Agencies should strongly consider consolidating into the fewest number of systems required to decrease redundancies, maximize revenue capture, improve accuracy, and streamline processes. This effort should be coordinated with LHD representatives throughout the state in order to determine the systems that provide the most ease of reporting, analysis, and accountability. **(ID: DIT-049)**

»» Public Health Record Digitalization

Digitize public health records (such as environmental health records) into secure systems while maintaining compliance with relevant state record retention policies to improve public access to records, increase government efficiency, and reduce costs associated with printing and storage space.

This will require funding to be made available to state and local health departments to contract out this work, hire adequate FTEs to oversee or implement, and acquire the new technology systems needed to house the digitized records. An iterative approach to digitization with guidelines for prioritizing the most essential paper records based on the demand and utilization by health departments and the public should be created. **(ID: DIT-048)**

Enhance Health-related Data Collection, Management, and Analysis Capabilities

Public health data is collected through many different systems. Only a fifth of the LHDs have fully automated case and syndromic surveillance reporting. Simplifying the number of platforms used by LHDs by identifying a universal platform and reducing the number of universal systems they use will better address the needs of LHDs and their communities. More automation will avoid duplicative work, free up staff time, and improve timely access to needed data, leading to quicker responses.

While accessing information from CRISP is already widespread among the LHDs, these recommendations will increase the ability to collect, access, link, analyze, interpret, and use data; assess and analyze disparities and inequities in the distribution of disease and social determinants of health that contribute to higher health risks and poorer health outcomes; and prioritize and respond to data requests and translate data into information and reports that are valid, complete, statistically accurate, and accessible to the intended audiences.

>>> Centralized Data Repository

Augment the Chesapeake Regional Information System for our Patients (CRISP), a health information exchange, to ensure that it is the primary centralized statewide data repository to receive structured data from multiple secure and approved sources, including healthcare, health departments, social service providers, and other relevant providers.

This reflects the goal of improving government efficiency by reducing the number of places to access data and streamlining data requests while promoting the interconnectivity of data sets that address social determinants of health. This does not preclude the use of additional interoperable data systems, if necessary. This repository should be utilized to its fullest extent and be able to organize, cultivate, link, and release data sets for multiple stakeholders to engage in research and QI, analytics, resource management, and public access to de-identified data. This will also require expanding the CRISP augmentation to include comprehensive ambulatory care data from health systems and private practice EMRs, and dedicating funding to incentivize primary care practices to participate in data sharing. **(ID: DIT-032)**

>>> State Electronic Health Record System

Determine and purchase a Universal Electronic Health Record (EHR) platform for MDH and all LHDs that can integrate as many of the six core foundational public health areas adopted by the Maryland Commission on Public Health as possible (Behavioral Health, Environmental Public Health, Communicable Disease Control, Chronic Disease and Injury Prevention, Maternal Child and Family Health, and Access to and Linkage with Clinical Care).

Input from counties should be incorporated to learn what EHRs are currently being used, the strengths and weaknesses of each system, what features are necessary for all jurisdictions, and how LHDs could customize the system to their own programs and workflows. Purchasing power should be leveraged to reduce costs and improve efficiencies of management and maintenance. If additional systems are required, ensure the minimum number of universal systems needed to achieve comprehensive public health data capture. All LHD and MDH EHRs should be required to participate in data exchange with CRISP and other applicable systems while encouraging a transition to one system. **(ID: DIT-035)**

»» Uniform Data Standards

Create and implement a uniform interoperability data standard for definitions and data sharing, including data use agreements across healthcare, social service, and public health systems.

A uniform master person index across data sets and unique systems should be ensured and a streamlined process of data use to maximize access to appropriate data for government and non-government agencies for use in tracking, research, and funding to demonstrate savings/return on investment should be developed. **(ID: DIT-033)**

»» Hub and Spoke Analytic Model

Organize a Hub (MDH) and Spoke (LHDs) model of analytic functions, with technical assistance and support to create consistency in outputs, efficiency in administration, and effective response to public health IT users.

A streamlined process for data use requests from constituent end users to facilitate timely analysis responses should be created. This model will allow more effective and efficient use of data for policies, programs, and research. **(ID: DIT-034)**

»» Data Use Efficiency

Streamline the processes of data use, including data use agreements across state and local government agencies, as well as non-government entities, in order to maximize access to data while maintaining appropriate confidentiality controls.

This data is routinely sent to the CDC, the Centers for Medicare & Medicaid Services (CMS), and others to analyze and publish. Increased access to data for applications in epidemiology, cost-benefit analysis, evaluation, and research will benefit public health outcomes, government efficiency, scientific advancement, and transparency while reducing the administrative burden for all entities. **(ID: DIT-036)**

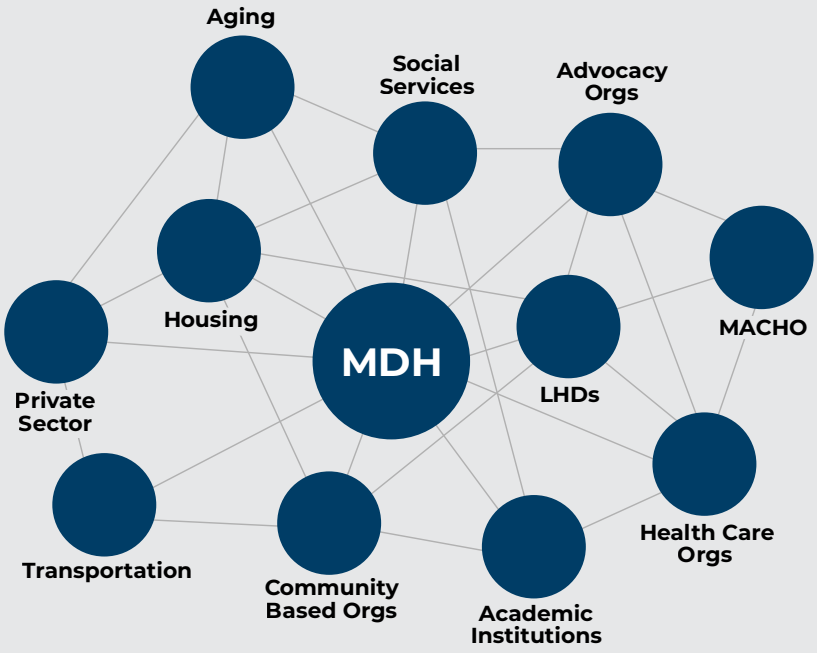
»» Laboratory System Assessment

Appropriate funding for an assessment of the laboratory system (public and private) to determine capacity, meet Maryland's public health needs, and address the most crucial upgrades needed to the public health laboratory system in Maryland.

The assessment should use recommendations from the HP2030 and the Association of Public Health Laboratories' (APHL) 2023 Public Health Laboratory Capability Assessment and consider whether there are potential elements that could be adopted from models such as Maryland's Active Bacterial Core Surveillance (ABCs) Emerging Infection Program (EIP) or other lab networks such as PulseNet, the Food Emergency Response Network, or the Laboratory Response Network. New technologies should be explored and incorporated such as wastewater surveillance for, and public reporting of, pathogens and toxins. The assessment should explore whether the Electronic Laboratory Reporting is used to best effect for data sharing and standardization. In addition, cooperative agreements with other (private or public) laboratories or ways to establish an alternative sustainable support framework in the case of the absence of federal support should be investigated. The assessment should investigate whether Maryland has a dedicated laboratory supply chain and/or stockpile that would be sufficient/able to meet increased demand during an emergency. If it doesn't already exist, fund a stockpile of any nonperishable laboratory materials. **(ID: CCR-058)**

THEME 3. Leverage and Formalize Partnerships

Partnerships in Maryland between the core governmental public health agencies, MDH and LHDs, and other entities involved in public health activities exist but are not always formal and enduring. Bidirectional community engagement, advice, and collaboration from our partners in academic institutions and leaders in the healthcare system serve to strengthen our core public health operations. MACHO serves as the collective voice and convener for all 24 LHDs and as liaison between local health officers and the MDH. Continuing consistent and equitable collaborations between state and local public health entities can ensure coordinated systemwide data-informed planning and evaluation, and performance management.



Strengthening collaborations between the public health service system in Maryland with primary care physicians and the healthcare delivery system will move Maryland toward better integration of prevention, early intervention, and management of disease conditions to improve health outcomes. The following recommendations call for actions to solidify partnerships with specific groups who could serve as allies and help maximize efficiency in a time of scarce resources.

Coordinate with Governmental Agencies

>>> Social Service, Housing, Aging, and Transportation Collaboration

Collaborate with state agencies that address social services, housing, and aging to better understand the needs of vulnerable populations, identify service gaps, and coordinate responses to benefit health.

MDH and LHDs will examine barriers and facilitators to multi-sector partnerships at the state, regional, and local level to include problem-solving teams, "no wrong door" initiatives, assessment of policies/practices for health impacts, exploration of increased funding opportunities, and shared data systems. **(ID: GOC-027)**

Partner with Academic Institutions

»» Academic Health Department Partnerships

Develop and support academic health department partnerships to enhance the organizational capabilities of governmental public health systems and enrich academic public health practice programs.

MDH, LHDs, and academic institutions should work towards implementing academic health department (AHD) models at state and local levels that involve formal agreements with academic institutions in the state, including Historically Black Colleges and Universities (HBCUs), Community Colleges, and Graduate Medical Education programs. This effort may involve establishing an AHD community of practice in Maryland to develop template memorandums of understanding (MOUs), suggested actions that academic institutions can take to meaningfully engage with health departments, and defining standards for a well-functioning AHD model in Maryland. The effort should include partnerships with local primary care residency training programs (such as in family medicine) and medical schools for resident/student rotations in public health settings. These partnerships could create a pipeline of clinicians who understand and value public health approaches, ultimately strengthening collaboration between clinical and public health sectors. Further analysis by an AHD community of practice could resolve barriers and create expedited pathways for LHDs and the state health department to formally engage staff/faculty from academic institutions in conducting public health work for the department - including assessments, data analysis, evaluations, cost-benefit analyses, support sabbatical/details of faculty to public agencies, and providing scientific/subject matter expertise. **(ID: GOC-026)**

Commission Chairs and Support Staff

TABLE 5. EXAMPLE PUBLIC HEALTH PARTNERS

State Agencies

- Department of Aging
- Department of Agriculture
- Department of Budget and Management
- Department of Education
- Department of Environment
- Department of General Services
- Department of Information Technology
- Department of Labor
- Department of Occupational Safety and Health

Advocacy Organizations

- Maryland Association of Counties
- Maryland Assembly on School Based Health Care
- Maryland Hospital Association
- Maryland Public Health Association
- Maryland Rural Health Association
- Mid-Atlantic Association of Community Health Centers
- Maryland Nurses Association
- Maryland Dental Action Coalition
- Maryland State Medical Society (MedChi)

Commissions and Other Entities

- Maryland Health Care Commission
- Chesapeake Regional Information System for our Patients (CRISP)
- Maryland Community Health Resources Commission
- Maryland Health Services Cost Review Commission

Umbrella Organizations

- Local Health Improvement Coalitions
- Board of Health
- Maryland Association of County Health Officers (MACHO)
- Maryland Association of Counties (MACo)

Health Care Service Delivery Partners

- Addiction treatment providers
- Hospitals
- Laboratories
- Mental health providers
- Primary care providers
- Pediatricians

Local Partners

- Elementary and secondary schools
- Correctional facilities
- Faith-based organizations
- Fire departments
- Homeless shelters
- Housing Authority
- Law enforcement
- Libraries
- Local boards (e.g., local boards of education)

Recovery support organizations

- Non-profit organizations
- Soup kitchens and food banks
- Transportation Authority
- YMCA Boys & Girls Clubs

Policymakers

- State Legislators
- County Executives

Academic Institutions and Health-related Programs

- Area Health Education Centers
- Extension programs

This list is not exhaustive, but it demonstrates the breadth of partnerships necessary for success in protecting and promoting the health and well-being of Marylanders.

Heighten Partnerships with Statewide Non-Profit Health Organizations

MACHO Partnership

Utilize MACHO as the collective voice for all 24 LHDs, the liaison between LHOs as a group and MDH, and the convener and collaborator to help achieve shared MDH-LHD shared goals, strengthen the public health workforce, and promote and advocate for public health messages.

MACHO will serve to facilitate interactions with other community advocacy and professional organizations to support communications, enhance collaborations, and expand the scale-up of successful programs. **(ID: PCP-066)**

Community, Advocacy and Professional Organizations

Formalize partnerships with statewide or national non-profit organizations by specifying the activities that align with goals of improving Maryland's population health.

These include prevention and primary care initiatives such as those provided by the Maryland Academy of Family Physicians and MedChi's Episode Quality Improvement Program (EQIP), which advance public health and primary care access. Partnerships between public health and state public health and professional associations may strengthen coalition-building, workforce development and informed advocacy. State and local public health leaders should share their expertise with these associations, support the enhancement of public health or population health initiatives, such as EQIP, and find ways to meaningfully engage statewide associations or their local affiliate chapters in community health efforts. **(ID: PCP-067)**

Strengthen Connections with Health Care Organizations

Private Sector Health Systems

Pursue collaboration with private sector health systems through partnerships, joint funding opportunities, research, communication, and coordination.

MDH will identify barriers and facilitators of state, regional, and LHD engagement with private sector health systems. MDH will review statutory, regulatory, and administrative barriers to establishing ethical and equitable public-private partnerships for funding to and from MDH and LHDs with the private sector. **(ID: GOC-029)**

Build Stronger Relationships with the Private Sector

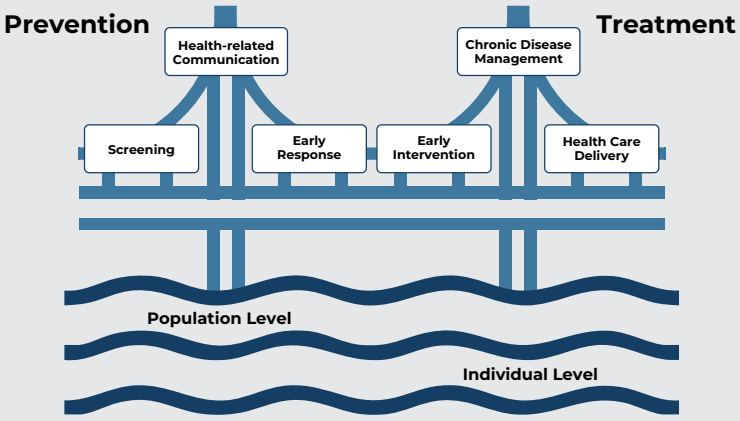
Public Health Business Advisory Board

Create a Public Health Business Advisory Board to stimulate investment in public health from the business sector.

This type of investment prevents health problems such as diabetes and substance use disorders that lead to higher employer costs. As a result of preventable somatic and behavioral health problems, Maryland businesses lose significant amounts of money to workplace absences, poor productivity, and workplace errors that result in injuries and lawsuits, employee turnover, and higher health insurance premiums. Partnerships with entities like the Maryland Chamber of Commerce, academia, and local and state officials could be used to support recruitment and general needs for the Advisory Board. **(ID: FND-010)**

THEME 4. Bridge Public Health and Health Care Service Delivery

Achieving optimum health requires a broad continuum of investments to ensure that individuals have opportunities to learn about healthy behaviors, screen regularly for potential health conditions, and treat illnesses when they occur with the best possible healthcare. The public health system is interdependent with the healthcare service delivery systems that exist in Maryland. The following recommendations call for improving the understanding of the public health system—what it is, what it does, and the goals it has for improving the health of all Marylanders. The recommendations detail actions that can build the needed synergy between the multiple entities that are focused on health and healthcare services.



Enhance Connections between Public Health, Primary Care, and Health Care Delivery Systems

As Chief Health Strategists for their jurisdictions, LHOs and their LHD teams have a unique understanding of the healthcare access barriers in their communities. These perspectives could benefit collaborative strategies to advance primary care in their jurisdictions. Limited primary care access in local jurisdictions heaps pressure on public health capacity while challenging the attainment of better public health outcomes. LHDs should support efforts to expand the primary care workforce in their communities. Advancing the primary care workforce necessitates a robust set of strategies, from establishing a pipeline to ensuring retention. A primary care workforce advisory body with involvement from local health officers, MDH leaders, clinical associations such as the Maryland Academy of Family Physicians, MedChi, and the state chapter of the American Academy of Pediatrics could meaningfully address Maryland's dire shortage of primary care clinicians. While existing or previous primary care groups have contributed to this need, such as the Maryland Health Care Commission Primary Care Program Advisory Council and the legislated Commission to Study the Healthcare Workforce Crisis, more robust involvement of state and local public health professionals and clinician associations would benefit this type of work.

»» Primary Care Workforce Support

MDH, in collaboration with LHDs and essential partners such as associations of primary care clinicians, should develop and implement strategies that enhance existing and create new incentive programs to expand and support the primary care workforce in Maryland. Maryland should implement a primary care workforce task force that involves local and state public health officials and primary care clinician associations, and develop a comprehensive plan of primary care workforce expansion strategies for Maryland from pipeline through retention.

Strategies should give special attention to the primary care shortages in rural areas, and consider options to support telehealth access to primary care clinicians working in Maryland. **(ID: CCR-056)**

»» Public Health and Primary Care Continuum

Acknowledge and support Maryland's LHDs' provision of basic primary care services in counties where there is a lack of clinical providers.

Together with the provision of foundational public health services, these services contribute to Maryland's health and healthcare improvement initiatives. Governmental public health is an essential component of Maryland's continuum of health, well-being, and healthcare. **(ID: CCR-065)**

»» Public Health Navigators

Create non-clinical and clinical-friendly "resource hubs," serviced by public health navigators (such as community health workers) and led by LHDs, within brick-and-mortar community locations (such as public shopping districts, schools, food bank locations, or Federally Qualified Health Centers (FQHCs), where residents can learn about and access assistance with a variety of health-related needs.

These spaces should have state-of-the-art technology and be able to provide information on a variety of topics, like home health for elderly populations, when to consider mental health assessments and how to access them if needed, the benefits of screening for medical and dental health, and many other public health-oriented activities. **(ID: CCR-055)**

Clarify Public Health Capabilities for the Legislature and the Public

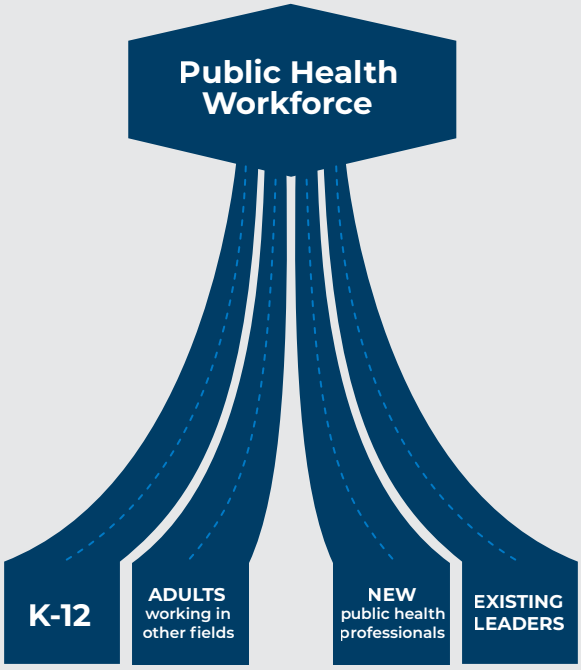
»» Elected Official Onboarding

Develop and provide onboarding education for LHDs on how to engage with newly elected state and local public officials about public health and responsibilities, including duties of local boards of health.

This will be created by LHDs, MACHO, and MDH to supplement the offerings of the Department of Legislative Affairs and the Maryland Association of Counties. **(ID: GOC-028)**

THEME 5. Pave the Way for Future Public Health Leaders

The current public health workforce is diverse with respect to disciplinary backgrounds and skill levels. The need for skills outside traditional public health roles is rapidly evolving based on new technologies and expanded forms of communication. Many individuals who work in the public health sector and have been trained in allied disciplines might need professional development opportunities to help them maximize the impact of their work. Currently, there is no mechanism for the state to identify current workforce capacities, deficiencies, and project future needs.



Younger people in our secondary and high schools must be given more opportunities to learn about public health as a career option, especially youth who have an interest in health, the social or biological sciences, government, policy, or information technology. Individuals interested in public health can choose to practice public health in government or other community-based settings and healthcare service organizations.

Combined with the aforementioned upgrades to the human resource system to allow for more appropriate job classifications and corresponding salaries, the following actions will result in the much-needed expansion of Maryland's public health workforce, improvement of the visibility of public health as a career, and an emphasis on making career pathways into governmental public health more attractive to individuals with interests in many disciplines.

Invest in Public Health Workforce Policy, Planning, and Professional Development

>>> Public Health Workforce Commission

Establish a multidisciplinary Public Health Workforce Commission to study, assess, and track the state and local governmental public health workforce throughout Maryland to inform workforce investments and policy decisions. The legislature should establish the commission, housed in partnership with qualified academic or research institutions, to provide strategic leadership and oversight of the state's public health workforce and its development.

Establishing this commission and a standardized reporting framework will equip Maryland with the infrastructure, expertise, and data necessary to proactively address workforce challenges, build capacity, and drive equitable, evidence-based policymaking. **(ID: WKF-012)**

>>> Statewide Public Health Workforce Training Strategy

Develop and implement a statewide public health workforce training strategy to ensure a well-prepared, effective, sustainable, and flexible governmental public health workforce aligned with Maryland's broader public health development goals and with a focus on professional development, advancing career pathways, expanding skills, improving job satisfaction and retention, and skill development for emerging public health challenges.

The legislature should allocate the necessary resources for this strategy to be developed in collaboration with academic institutions, LHDs, and other key partners, and could be led by MDH or a new Public Health Workforce Commission. **(ID: WKF-013)**

>>> IT and Analytics Workforce

Invest in a state public health information technology (IT) workforce by supporting academic centers in training the current and future workforce in information technology, data science, computing technology, information systems, software development, human-centered design, agile project management, product management, and data analytics.

The public health information technology workforce retention should be incentivized through loan forgiveness, in-state tuition and following commitment to public sector employment. The savings from consolidation of electronic systems to translate into more competitive hiring practices for public health information technology professionals could be used and a hybrid IT workforce that places individuals at the point of maximal effectiveness should be encouraged. **(ID: DIT-047)**

Design and Develop Innovative Educational and Experiential Offerings

>>> Maryland Corps to Public Health Careers

Expand the existing Maryland Corps program under the Department of Service and Civic Innovation to include a dedicated public health pathway into governmental public health careers. *With this change, the legislature would support a structured, service-based entry point into careers within the MDH and LHDs. With the direct input of the LHDs, this initiative would build a diverse, skilled, and mission-driven pipeline of future public health professionals equipped to meet the state's evolving health needs.* **(ID: WKF-016)**

>>> Youth Education Public Health Literacy

Support providing an age-appropriate, standards-aligned, and culturally relevant PreK-12 public health curricula, such as that being developed by the Comprehensive Health Education Standards & Frameworks Validation Committee (SFVC)[38] and setting standards that outline a specific number of minutes for health education for students and specified education requirements for who is allowed to teach health education classes.

SFVC provides the Maryland State Board of Education with a recommendation to revise or validate the current comprehensive health education standards and framework by studying emerging state and national public health trends to ensure Maryland's PreK-12 comprehensive health education programs meet the complex needs of all students. SFVC is composed of parents, teachers, local education agency leaders, and associated content experts. The Commission supports curricula that will increase familiarity with and literacy of public health concepts, such as chronic and infectious disease, disease prevention, health equity, communication, mental and emotional health, and critical thinking. It is important to familiarize these concepts in students so that as adults, community members will have improved understanding of personal and public health and also inspire them to join the public health work-force. **(ID: CPE-019)**

Chesapeake Bay, MD

SECTION 4

Moving Maryland Forward

AREAS FOR FUTURE EXPLORATION

The Commission acknowledges that it did not address every sector of the Maryland public health system. There were findings from the workgroups or in the Assessment Report that it did not address in formally approved recommendations. These are ideas that may have needed different participants, alternate research methods, more time, or other resources. Some of these limitations have led to recommendations by the Commission for future work, while others have been listed as suggestions for other groups to study.

Maryland Commission on Public Health

The Commission considered several recommendations that were not chosen for approval in the final slate. These were not approved because the Commission could not reach consensus or additional research was necessary. Some of these topic areas are listed below in the hope that future commissions or other interested groups will be able to explore them further. Topic areas that were brought up for consideration by workgroups but did not become full recommendations include:

- Utilizing MDH Roundtables for Increased Collaboration
- Organizing a Call to Action for Academic Partners in Public Health
- Establishing a Public Health Career Pathways Program
- Utilizing Community Benefit Spending for LHDs and MDH
- Restructuring LHDs' Governmental Structures
- Establishing a Communication and Public Engagement Liaison Program
- Publishing and Evaluating Maryland specific data independently from the U.S. Centers for Disease Control and Prevention (CDC)

The Commission also recommends exploring additional partnerships and maintaining the synergy the Commission's relationships have built. MACHO has been a key partner in this work and is a potential torchbearer to implement the recommendations in this work. The Commission did not fully explore how the activities and roles of the Maryland Department of the Environment can be leveraged to support public health efforts, but it suggests they could be a key player in enacting these proposals.

The Commission also faced limitations that prevented it from doing more. Limitations include time—the Commission had only a year and a half to study the state of Maryland's public health. Another limitation was resources. The Commission was created initially without any dedicated funding, and all Commission and workgroup members were volunteers who had day-to-day job responsibilities. The revision of the statute to

encumber a small amount of state funds in the next fiscal year was helpful. The Commission is grateful for the in-kind resources provided by key partners and for the significant funding support provided by philanthropic organizations to the CDC Foundation. The philanthropic support allowed for the dedicated staffing supporting the Commission, without which the scale of this work would not have been possible.

The academic team listed several important areas that they were not able to fully explore during its assessment activities and conversations, including the cost-effectiveness of prevention strategies, funding models, and the role of the insurance industry in healthcare access, especially in relation to primary care. There was not comparable input from various constituent groups that were interviewed nor was there equal participation from state and local levels of government. It was easier to get LHD data than state data. Thus, the Commission's recommendations may carry an unintentional bias toward local health concerns. A more comprehensive list of limitations is available in the assessment report.[1]

MOVING MARYLAND FORWARD

The Commission's work began with a vision where "every Maryland community flourishes with equitable access to comprehensive public health services, empowering everyone to achieve well-being and improved health outcomes." The recommendations detailed in this report provide a roadmap for making that vision a reality.

The following actions are offered for consideration:

1	First, the Commission's work during the past two years has galvanized discussions between the public, community partners, policy makers, leaders of local and state governmental entities, as well as health-related organizations and systems across the nation. These dialogues might not have occurred with such intentionality if it were not for the needs of the Commission. The Commission is enthusiastic about continuing these important discussions in the spirit of collaboration and consensus-building.
2	Second, because the Commission's discussions underscored the complexity and interrelatedness of the different health challenges Maryland will face in the future, responsibilities and support for coordination of the various components of the roadmap need to be determined. There was a multitude of partners who were essential to the process of examining our public health system and envisioning the best future for it, and they will need to be involved in the implementation of these recommendations. The Commission anticipates that the recommendation to establish a Public Health Resource Team (ID: GOC-042) will be essential for securing the personnel needed to coordinate the work ahead.
3	Third, briefings for policymakers by Commission members will provide additional details on operationalizing some of the recommendations. These meetings can be opportunities for legislators to reflect on how these recommendations align with their own priorities—to make their local communities and the state healthier and more economically viable. These meetings will continue until the Commission sunsets in June 2026.

4 Fourth, Maryland must prioritize categorizing the implementation order of the recommendations within the five thematic areas. Some recommendations can be enacted quickly, like strengthening internal communications, and require little fiscal or human resources. Some recommendations may be aligned with planned and ongoing MDH and other state department and agency improvements and thus provide an opportunity to accelerate their implementation. Other recommendations can be implemented in the short-term but will require strategic fiscal investments and legislation. Others are longer-term and more aspirational, requiring additional systematic planning prior to implementation.

Moving Maryland toward a better state of health is achievable. The Commission's work has revealed a deep bench of expertise in Maryland and throughout the public health infrastructure. With sufficient support, coordination, and public engagement, Maryland can build on its existing assets to equitably enhance the health of all Marylanders.

Chestertown, MD

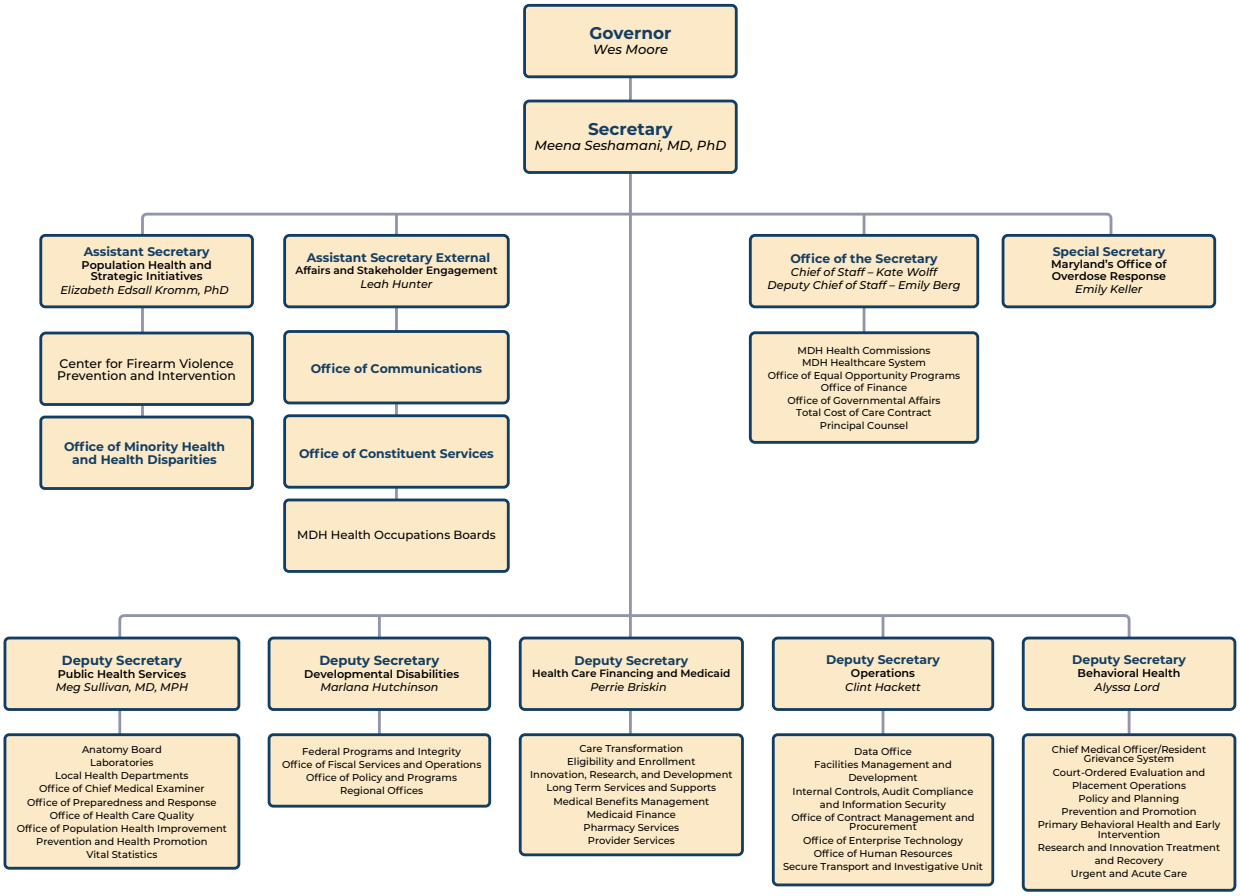
Appendices

APPENDIX 1: ACRONYMS AND TERMS USED IN THIS REPORT

Acronym	Term
ABCs	Active Bacterial Core Surveillance
AHEAD	Achieving Healthcare Efficiency through Accountable Design
AHD	Academic Health Department
AI	Artificial Intelligence
APHL	Association of Public Health Laboratories
ASTHO	Association of State and Territorial Health Officials
BBH	Babies Born Healthy Program
BHB	Baltimore City B'more for Healthy Babies
BOH	Board of Health
CDC	Centers for Disease Control and Prevention
CHNA	Community Health Needs Assessment
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for our Patients
DBM	Maryland Department of Budget and Management
EBPH	Evidence-Based Public Health
EHR	Electronic Health Record
EIP	Emerging Infection Program
EQIP	MedChi's Episode Quality Improvement Program
FERPA	Family Educational Rights and Privacy
FPHC	Foundational Public Health Capabilities
FPHS	Foundational Public Health Services
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
HHS	Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Information Portability and Accountability Act
HRSA	Health Resources Services Administration
HSCRC	Maryland Health Services Cost Review Commission
IT	Information Technology
LBHA	Local Behavioral Health Authorities
LHD	Local Health Department
LHO	Local Health Officer
MACHO	Maryland Association of County Health Officers
MACo	Maryland Association of Counties
MCHRC	Maryland Community Health Resource Commission
MDEM	Maryland Department of Emergency Management
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MHCC	Maryland Health Care Commission
MRC	Maryland Medical Reserve Corps
NACCHO	National Association of County and City Health Officials
PHAB	Public Health Accreditation Board
PH WINS	Public Health Workforce Interests and Needs Survey
PIO	Public Information Officer
SFVC	Standards & Frameworks Validation Committee
SHIP	State Health Improvement Plan
SIHIS	Statewide Integrated Health Improvement Strategy
SHA	State Health Assessment
TCOC	Total Cost of Care
The Commission	The Maryland Commission on Public Health

Term	Description
Governmental Public Health	This includes the MDH, LHDs, and the delegated responsibilities to LHDs from the Department of the Environment.
Public Health System	This includes governmental public health and other governmental entities with regulatory responsibilities for public health, as well as public, private and non-profit partners, including state and local community-based, professional, advocacy, academic, and other health-related organizations.
Essential Public Health Services	These are the services the public health system at all levels should undertake and effectively deliver to protect and promote the health of all people in all communities. See: https://www.apha.org/what-is-public-health/10-essential-public-health-services
Foundational Public Health Services	As described by the Public Health Accreditation Board, this is the minimum package of public health capabilities and programs that no jurisdiction (governmental public health) can be without. See: https://phaboard.org/infrastructure/public-health-frameworks/the-foundational-public-health-services/
Shared Governance	Maryland's arrangement for governmental public health is categorized as a "largely shared" governance model. According to the Association of State and Territorial Health Officials (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 issue public health orders. See: https://www.astho.org/globalassets/pdf/state-local-governance-classification-tree.pdf
Super-Agency	A large, umbrella organization in state government that includes multiple related departments managed by a single cabinet-level secretary. MDH is a super-agency. Note: "In 45 percent of all states, the health department is one unit in a larger umbrella agency (or "super-agency") that includes a variety of functions, such as mental health services, public assistance, long-term care, and human services, in addition to traditional public health functions." See: https://www.publichealthlawcenter.org/resources/state-local-public-health-overview-regulatory-authority

APPENDIX 2: MARYLAND DEPARTMENT OF HEALTH ORGANIZATION CHART



APPENDIX 3: SUMMARY OF SPEAKER PRESENTATIONS

The Commission invited a variety of experts to 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 at *https://health.maryland.gov/coph/Pages/Meeting-Dates.aspx*.

These presentations included:

- ***Indiana's Process*** – Dr. Judith Monroe, President and CEO, CDC Foundation
- ***Overview of Maryland's Local Public Health Infrastructure*** – Bob Stephens, Garrett County Health Officer and President of the 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, Senior 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
- ***One Health and What You Can Do About It Today*** – Dr. Deborah Thomson, Founder & Executive Director, One Health Lessons
- ***National Landscape on Public Health Authority: Ups and Downs and All-Arounds*** – Kathi Hoke, Professor and Director, Eastern Region of Network for Public Health Law
- **Serena McIlwain, Maryland Secretary of the Environment, Maryland Department of the Environment**
- ***Maryland Commission on Public Health: Update from Academic Partner Assessment Team*** – Dr. Amelia M. Arria, Professor and Associate Dean for Strategic Initiatives, University of Maryland School of Public Health; Brittany Bugbee, Senior Faculty Specialist, University of Maryland School of Public Health
- ***The Future of Public Health: How to Prepare for the Future at a Time of Loss*** – John Auerbach, Senior Vice President for Public Health, ICF

Workgroups also invited a variety of experts to present on relevant topics during their monthly meetings. These presentations, organized by workgroup, are listed below:

Communication and Public Engagement

- ***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, Maryland Department of Health
- ***The Commission's Workgroup Charters and Timeline*** – Shane Hatchett, Principal and Founding Member, Advent Solutions

Data and Information Technology

- ***Modernizing Public Health via Health Information Exchange and Governance*** – Dr. Brian Dixon, Director of Public Health Informatics, Regenstrief Institute, Inc. and Indiana University Richard M. Fairbanks School of Public Health

- ***MDH Data Modernization*** – Marcia Pearlowitz, Data Modernization Director, Maryland Department of Health
- ***LHD Data Modernization*** – Mantai Murry, IT Manager, Prince George's County Health Department

Funding

- ***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, Maryland Department of Health
- ***Public Health Grant Management*** – Michelle Moore, Director of Grants and Local Health Accounting, MDH and Irma Bevins, Advisor of Grants and Local Health Accounting, Maryland Department of Health
- ***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

Governance and Organizational Capabilities

- **Jon Kromm,** Executive Director, Maryland HSCRC
- **Mary Bearden,** Senior Counsel, Maryland Office of the Attorney General

Workforce

- **Dr. Allison Chamberlain,** Research Associate Professor, Department of Epidemiology, Director of Research and Practice Relations with the Georgia Department of Public Health, 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

APPENDIX 4: LIST OF CURRENT AND FORMER MEMBERS

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, BSN, 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
Maryland Department of Health

Christopher Brandt, MBA
Managing Director
Audacious Capital

Jean Drummond, MPA
President and CEO
HCD International

Gregory Branch, MD, MBA, CPE, FACP
Former Member
Former Directory of Health and Human Services
Baltimore County Government

Elizabeth Kromm, PhD
Designee of Deputy Secretary Meg Sullivan
Assistant Secretary, Population Health and Strategic Initiatives
Maryland Department of Health

Nilesh Kalyanaraman, MD, FACP
Former Member
Former 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
Deputy Health Officer
Carroll County Health Department

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

Fran Philips, RN, MHA Former Member 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
Allen Twigg, LCPC, MBA Executive Director Behavioral & Community Health Brook Lane	**Vacant** Urban Local Health Officer

Commission Support Team

Hawi Bekele Bengessa, MHA Communications Support Senior Content Designer AbleTo Inc	**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	**Joshua Veale** Commission & Workgroup Staff Support College of Health Professions Coppin State University
Shane Hatchett, MS Senior Advisor & Commission Manager CDC Foundation and St. Mary's County Health Department	**Dushanka Kleinman, DDS, MScD** Technical Advisor Professor Emerita University of Maryland School of Public Health
Sarah Kolk, MPH Commission Support Staff Johns Hopkins University Bloomberg School of Public Health and St. Mary's County Health Department	**Negin Fouladi, PhD, MPH, MS** Clinical Professor & Director of Online Graduate Programs, Department of Health Policy and Management, University of Maryland School of Public Health Chair, Universitas21 Health Research Exchange Community of Practice
Michelle Kong, BA Commission & Workgroup Staff Support Assistant to the Dean University of Maryland School of Public Health	**Kristine Lawrance, MPA** Technical Writer Lawrance Policy Consulting

Yonathan Mesfun
Meeting Support
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 Hawkins, 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

Oluwatosin Olateju, DrPH, MSN-CPHN, BSN, RN
Assistant Professor of Nursing, Coppin State University
Adjunct Professor, Morgan State University School of Community Health and Policy

Communication and Public Engagement Workgroup

(= Appointed Member of Commission on Public Health)*

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Tonii Gedin, RN, DNP
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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

Dianna 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

Roselie Bright, ScD, MS
Volunteer Epidemiologist

Stacy Cary-Thompson, MD
Pediatrician
Cary Cares Parenting LLC

Saniya Chaudhry, PharmD
Pharmacist

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 Department of Health & Human Services

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 & Dir. of Online Grad. 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, NE-BC 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, BSN* 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, MPH** 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, MPH** 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

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

Matthew Levy, MD, MPH, FAAP*
Deputy Health Officer
Carroll County Health Department

Workgroup Members

Adejare Atanda, DMD, DrPH, MPH
Former Co-Chair
Senior Policy Advisor
RAND Corporation

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

Brice Strang
Health Officer
Queen Anne's County 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

James Yoe
Director of Behavioral Health Research and Innovation
Behavioral Health Administration
Maryland Department of Health

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Health Officer
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(= Appointed Member of Commission on Public Health)*

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APPENDIX 5: ANNOTATED CODE AND THE CODE OF MARYLAND REGULATIONS FOR MDH AND LHDS

MD Code, Health - General, § 2-302
§ 2-302. Minimum funding amounts

Currentness

(a) The funding required in the State budget for local health services, exclusive of special fund and federal appropriations, shall be at least the amount set forth in subsection (b) of this section.

(b) The funding shall be:

(1) For fiscal years 2019, 2020, 2021, 2022, 2023, and 2024, the amount of funding provided through the formula for the preceding fiscal year adjusted for:

(i) Inflation, as measured by the Consumer Price Index (All Urban Consumers), on June 30 of the second preceding fiscal year, calculated by the Bureau of Labor Statistics of the U.S. Department of Labor; and

(ii) Population growth, as measured by the growth in the total population of the State on June 30 of the second preceding fiscal year, according to the most recent statistics available through the U.S. Department of Commerce;

(2) For fiscal year 2025, $70,000,000, to be distributed to each municipality or subdivision in the same proportion as the fiscal year 2024 funding distributed to each municipality or subdivision;

(3) For fiscal year 2026, $80,000,000, to be distributed to each municipality or subdivision in the same proportion as the fiscal year 2025 funding distributed to each municipality or subdivision; and

(4) For fiscal year 2027 and each subsequent fiscal year, the greater of:

(i) The funding provided by the formula for the immediately preceding fiscal year; or

(ii) The actual funds appropriated for the immediately preceding fiscal year, adjusted for:

1. Inflation, as measured by the Consumer Price Index (All Urban Consumers), on June 30 of the second immediately preceding fiscal year, calculated by the Bureau of Labor Statistics of the U.S. Department of Labor; and

2. Population growth, as measured by the growth in the total population of the State on June 30 of the second immediately preceding fiscal year, according to the most recent statistics available through the U.S. Department of Commerce.

(c) For fiscal year 2027 and each subsequent fiscal year, no subdivision may receive less State funding for local health services under this section than that subdivision received in fiscal year 2026.

(d) The Secretary shall, in consultation with local health department directors, adopt regulations to guide the distribution of the funding required under this section. The regulations shall give consideration to appropriate measures of community health need, local funding effort, and other relevant factors.

Credits

Added by Acts 1995, c. 504, § 1, eff. July 1, 1995. Amended by Acts 2010, c. 72, § 1, eff. April 13, 2010; Acts 2010, c. 484, § 3, eff. June 1, 2010; Acts 2014, c. 464, § 1, eff. June 1, 2014; Acts 2017, c. 23, § 1, eff. June 1, 2017; Acts 2017, c. 62, § 6; Acts 2018, c. 10, § 1, eff. June 1, 2018; Acts 2021, c. 805, § 1, eff. June 1, 2021.

MD Code, Health - General, § 2-302, MD HEALTH GEN § 2-302

Current through legislation effective through May 6, 2025, from the 2025 Regular Session of the General Assembly. Some statute sections may be more current, see credits for details.

APPENDIX 6: TIMELINE OF RELATED HEALTH EFFORTS IN MARYLAND

The Commission's work was not the only public health activity in Maryland during this period. Professionals across the state were also working on the same issues. The Commission has stood beside these efforts and leveraged their expertise to build upon its work.

- **May 2024:** The Community Health Resources Commission awarded funding to 12 grantees to expand access to healthcare 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 the Centers for Medicare & Medicaid Services (CMS) Achieving Healthcare Efficiency through Accountable Design (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.
- **September 2024:** The Maryland Department of Health (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" was 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 was required to 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.[39]
- **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.[40]
- **October 2024:** During the last legislative session, the Department of Legislative Services requested a report to clarify funding streams for LHDs.
- **April 2025:** Dr. Meena Seshamani assumed the post of Secretary of the Maryland Department of Health. Dr. Meg Sullivan was appointed Deputy Secretary of Public Health.

- **July 2025:** Federal bill H.R.1 was passed, which included several changes for state public health programs. These include reductions in funding for Medicaid and health insurance subsidies, adjustments to Medicaid eligibility for certain legal immigrants, the introduction of new work requirements for Medicaid, and changes to how states can finance their share of Medicaid through provider taxes and state-directed payments. The bill also shifts a portion of Supplemental Nutrition Assistance Program (SNAP) costs to states. These provisions may increase administrative responsibilities and financial pressures on state governments. Potential impacts could include changes in health coverage levels, access to nutrition assistance, and sustainability of healthcare services, particularly in rural or underserved communities.
- **September 2025:** The CMS Innovation Center announced new policy and operational changes, as well as a new end date, to the AHEAD model to help states achieve their total cost of care targets, while advancing the Center's commitment to promote choice and competition, increase prevention, empower patients, and protect taxpayer dollars. Changes will be implemented across all cohorts beginning in January 2026. AHEAD's end date for all cohorts is now December 31, 2035.

APPENDIX 7: ALL RECOMMENDATIONS ORGANIZED BY WORKGROUP

Cross Cutting

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Public Health Navigators	Create non-clinical and clinical friendly "resource hubs," led by local health departments, within brick-and-mortar community locations (such as public shopping districts, schools, food bank locations, or Federally Qualified Health Centers (FQHCs), where residents can learn about and access assistance with a variety of health-related needs. These spaces would be serviced by public health navigators, such as community health workers; have state-of-the-art technology; and be able to provide information on a variety of topics, like home health for elderly populations, when to consider mental health assessments and how to access them if needed, the benefits of screening for medical and dental health and many other public health-oriented activities.	CCR-055	Likely
Primary Care Workforce Support	The Maryland Department of Health (MDH), in collaboration with local health departments (LHDs) and essential partners such as associations of primary care clinicians, should develop and implement strategies that enhance existing and create new incentive programs to expand and support the primary care workforce in Maryland. Strategies should give special attention to the primary care shortages in rural areas, and consider options to support telehealth access to primary care clinicians working in Maryland.	CCR-056	Exists (some); Y (new)
Laboratory System Assessment	Appropriate funding for an assessment of the laboratory system (public and private) to meet Maryland's public health needs. Determine capacity and address the most crucial upgrades needed to the public health laboratory system in Maryland using recommendations from the HP2030 and the Association of Public Health Laboratories' (APHL) 2023 Public Health Laboratory Capability Assessment. Consider whether there are potential elements that could be adopted from models such as Maryland's Active Bacterial Core Surveillance (ABCs) Emerging Infection Program (EIP) or other lab networks such as PulseNet, the Food Emergency Response Network, or the Laboratory Response Network. Explore and incorporate new technologies, such as wastewater surveillance for, and public reporting of, pathogens and toxins. Explore whether the Electronic Laboratory Reporting is used to best effect for data sharing and standardization. Explore cooperative agreements with other (private or public) laboratories or ways to establish an alternative sustainable support framework in the case of the absence of federal support. Investigate whether Maryland has a dedicated laboratory supply chain and/or stockpile that would be sufficient/able to meet increased demand during an emergency. If it doesn't already exist, fund a stockpile of any nonperishable laboratory materials.	CCR-058	N

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Health-Related Funds	Savings from the healthcare financing and delivery system should be reinvested into a fund to advance prevention, population health, and public health. Supported strategies should be informed by input from a variety of public health stakeholders, including public health agencies, professional clinician associations, and community organizations. LHOs as chief health strategists should be leveraged for steering implementation in their jurisdictions.	CCR-063	Y
Public Health Foundational and Behavioral Health Services	Examine the different functions performed by Local Behavioral Health Authorities (LBHAs) and better allocate those functions to ensure that communities are getting the best integrated services. Preventive and early intervention services, such as suicide prevention education, harm reduction, data mapping, are core public health work and should be integrated into LHDs in jurisdictions where this is not already the case. These services are analogous to other core public health services provided by LHDs and would allow better integration and greater efficiency across the public health continuum at a local level. The oversight and regulatory functions can operate through either LHDs with integrated LBHAs or via separate LBHAs, but a more consistent mechanism reduces complexity in the system and allows for greater efficiency with public dollars services.	CCR-064	N
Public Health and Primary Care Continuum	Acknowledge and support Maryland's LHDs' provision of basic primary care services in counties where there is a lack of clinical providers. Together with the provision of foundational public health services, these services contribute to Maryland's health and healthcare improvement initiatives. Governmental public health is an essential component of Maryland's continuum of health, wellbeing, and healthcare.	CCR-065	Y

Communications and Public Engagement

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Plain Language Support	Provide funding to support dedicated access to plain language experts and contracts for public agencies, especially the MDH and LHDs, to ensure that all public information shared by Maryland state and local agencies uses plain language in accordance with Maryland laws and executive orders. This recommendation builds on Maryland's commitment to plain language support (HB1082), Maryland's Consumer Health Information Hub directed by the Horowitz Center for Health Literacy, and Maryland's Executive Order on Plain Language.	CPE-001	N
Language Access Support	Provide new and dedicated funding for public agencies, especially MDH and LHDs, to support dedicated translation and interpretation services, including languages other than Spanish, and to increase bilingual/multilingual staff in health departments to ensure that all public information shared by Maryland state and local agencies are in accordance with Maryland laws and executive orders on language access. Currently, Maryland provides a blanket contract mechanism for public agencies to streamline procurement of these services, but each agency must identify its own funds.	CPE-002	Exists
Public Feedback	Provide funding to support concerted and documented public feedback on public health information, programs, and services, and to ensure that health departments engage in ongoing, bi-directional feedback with the public. This recommendation provides support for a stable messaging system that would include feedback loops to evaluate to what extent public health messages, programs and services reach intended audiences and how feedback can continuously improve public access to these activities.	CPE-003	N
LHD PIO Leadership	Appoint a full-time dedicated public information officer (PIO) for each LHD to ensure that communities are informed and prepared to understand and act on public health information, programs, and services.	CPE-004	N
Health Communications Tools Modernization	Utilize all available and relevant communication methods, tools, and partnerships to ensure health departments are meeting community needs and promoting modernization and expansion of health communications messages. Updating and modernizing health communication tools could improve communication reach and accessibility through modern tools like SMS alerts, chatbots, and interactive portals for timely, multilingual communication.	CPE-005	N
Community Health Needs Assessment Support for LHDs	Secure necessary resources for LHDs to effectively complete and use data from Community Health Needs Assessments (CHNAs) by dedicating full-time staff and support for collaboration with local hospitals, school-based health centers or community health centers and thus reduce duplication of efforts, align priorities, and improve implementation of community health strategies.	CPE-018	N

Youth Education Public Health Literacy	Support providing preK-12 age-appropriate, standards-aligned, and culturally relevant public health curricula, such as that being developed by the Comprehensive Health Education Standards & Frameworks Validation Committee (SFVC) and setting standards that outline a specific number of minutes for health education for students and specified education requirements for who is allowed to teach health education classes. SFVC provides the Maryland State Board of Education with a recommendation to revise or validate the current comprehensive health education standards and framework by studying emerging state and national public health trends to ensure Maryland's PreK-12 comprehensive health education programs meet the complex needs of all students. SFVC is composed of parents, teachers, local education agency leaders, and associated content experts. The Commission supports curricula that will increase familiarity with and literacy of public health concepts, such as chronic and infectious disease, disease prevention, health equity, communication, mental and emotional health, and critical thinking. It is important to familiarize these concepts in students so that as adults, community members will have improved understanding of personal and public health and also inspire them to join the public health workforce.	CPE-019	Y
Health Communications Development and Dissemination	Prioritize existing funding or allocate additional funding, to promote the development and dissemination of health communications materials to the public. This should enhance public health agency communication capacity, foster engagement with the public, and reduce rumors and misinformation. Public health agencies should collaborate with partner organizations, such as associations of primary care clinicians, to increase the reach of important public health messaging to specific target audiences.	CPE-020	N
Visibility of Public Health	Develop a communications initiative, such as a "Maryland Public Health Issue of the Month" series run by MDH in collaboration with LHDs and academic partners, to enhance the visibility of the valuable public health work going on at the local level, clarify the scientific evidence around a timely public health topic, or call attention to an emerging issue or outbreak. Highlight and engage experts who may be from additional sectors, such as local and national professional associations, nonprofit organizations, volunteers, academia, public agencies, and other countries. Leverage existing efforts, such as the national Public Health Communications Collaborative, and collaborate with key partner organizations, such as MACHO and associations of primary care clinicians.	CPE-045	N

Data and Information Technology

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Centralized Data Repository	Augment the Chesapeake Regional Information System for our Patients (CRISP), a health information exchange, to ensure that it is the primary centralized statewide data repository to receive structured data from multiple secure and approved sources, including healthcare, health departments and social service providers and other relevant providers. This reflects the goal of improving government efficiency by reducing the number of places to access data and streamlining data requests while promoting the interconnectivity of data sets that address social determinants of health. This does not preclude additional interoperable data systems, if necessary. This repository should be utilized to its fullest extent and able to organize, cultivate, link, and release data sets for multiple stakeholders to engage in research and QI, analytics, resource management and public access to de-identified data. This also will require expanding the CRISP augmentation to include comprehensive ambulatory care data from health systems and private practice EMRs, and dedicating funding to incentivize primary care practices to participate in data sharing.	DIT-032	Y
Uniform Data Standards	Create and implement a uniform interoperability data standard for definitions and data sharing including data use agreements across healthcare, social service, and public health systems. A uniform master person index across data sets and unique systems should be ensured and a streamlined process of data use to maximize access to appropriate data for government and non-government agencies for use in tracking, research, and funding to demonstrate savings/return on investment should be developed.	DIT-033	N
Hub and Spoke Analytic Model	Organize a Hub (MDH) and Spoke (LHDs) model of analytic functions, with technical assistance and support to create consistency in outputs, efficiency in administration, and effective response to public health IT users. A streamlined process for data use requests from constituent end users to facilitate timely analysis responses should be created. This model will allow more effective and efficient use of data for policies, programs, and research.	DIT-034	N
State Electronic Health Record System	Determine and purchase a Universal Electronic Health Record (EHR) platform for MDH and all LHDs that can integrate as many of the six core foundational public health areas adopted by the Maryland Commission on Public Health as possible (Behavioral Health, Environmental Public Health, Communicable Disease Control, Chronic Disease and Injury Prevention, Maternal Child and Family Health, and Access to and Linkage with Clinical Care). Input from counties should be incorporated to learn what EHRs are currently being used, the strengths and weaknesses of each system, what features are necessary for all jurisdictions and how LHDs could customize the system to their own programs and workflows. Purchasing power should be leveraged to reduce costs and improve efficiencies of management and maintenance. If additional systems are required, ensure the minimum number of universal systems needed to achieve comprehensive public health data capture. All LHD and MDH EHRs should be required to participate in data exchange with CRISP and other applicable systems while encouraging a transition to one system.	DIT-035	N

Data Use Efficiency	Streamline the processes of data use, including data use agreements across state and local government agencies, as well as non-government entities, in order to maximize access to data while maintaining appropriate confidentiality controls. This data is routinely sent to the CDC, the Centers for Medicare & Medicaid Services (CMS), and others to analyze and publish. Increased access to data for applications in epidemiology, cost-benefit analysis, evaluation, and research will benefit public health outcomes, government efficiency, scientific advancement, and transparency while reducing the administrative burden for all entities.	DIT-036	N
Commission on Data and Information Systems Modernization	Establish a standing commission of public (including MDH, LHDs, Maryland Department of IT [DoIT], and CRISP) and private partners to identify opportunities and strategies for ongoing modernization of public health data and information systems. The commission could consider evolving technologies such as Artificial Intelligence (AI) and make recommendations for the state's public health system to improve efficiency, support flexibility, and ensure security and effectiveness	DIT-046	Y
IT and Analytics Workforce	Invest in a state public health information technology (IT) workforce by supporting academic centers in training the current and future workforce in information technology, data science, computing technology, information systems, software development, human-centered design, agile project management, product management and data analytics. The public health information technology workforce retention should be incentivized through loan forgiveness, in-state tuition and following commitment to public sector employment. The savings from consolidation of electronic systems to translate into more competitive hiring practices for public health information technology professionals could be used and a hybrid IT workforce that places individuals at the point of maximal effectiveness should be encouraged.	DIT-047	Y - funding
Public Health Record Digitalization	Digitize public health records (such as environmental health records) into secure systems while maintaining compliance with relevant state record retention policies to improve public access to records, increase government efficiency, and reduce costs associated with printing and storage space. This will require funding to be made available to state and local health departments to contract out this work, hire adequate FTEs to oversee or implement, and acquire the new technology systems needed to house the digitized records. An iterative approach to digitization with guidelines for prioritizing the most essential paper records based on the demand and utilization by health departments and the public should be created.	DIT-048	N
Efficiency of Business Functions	Assess and implement streamlined technology platforms and databases to improve the efficiency of health department business functions, such as budgeting/finance, accounts receivable, human resources, procurement, medical billing, and grants management. Agencies should strongly consider consolidating into the fewest number of systems required to decrease redundancies, maximize revenue capture, improve accuracy, and streamline processes. This effort should be coordinated with LHD representatives throughout the state in order to determine the systems that provide the most ease of reporting, analysis, and accountability.	DIT-049	Maybe; reporting requirements

Environmental Health Systems	Identify and procure an environmental health system to be used by the Maryland Department of the Environment, MDH, and LHDs to improve efficiency of permitting for state and local agencies, and the general public. This will create improved accountability, increased constituent satisfaction, and ideally attract more business to the state and local jurisdictions. While ideally incorporated into a universal electronic health record (EHR), Environmental Health poses unique challenges including permit capture and online payments, public input and tracking of licensure, complaints, investigations, and other unique functions. Additionally, this system would allow for improved reporting and analysis. Development of a system should maintain interoperability with local county systems and be informed by local input.	DIT-050	Y; reporting requirements
Five Year Enterprise Data and IT System Plan	Design and implement a 5-year enterprise data and information technology (IT) system architecture plan (or "Roadmap") for state and local health departments to ensure a coordinated strategy that creates funding and resource predictability, and improves planning as well as system awareness, transparency and constituent buy-in. This plan should build in flexibility and checkpoints to pivot to market and technology changes.	DIT-051	N
Information Technology	Create a separate mechanism for annual funding of technology (outside of LHD Core Funding) that supports the current and emerging technology needs for public health at the state and local level (MDH and LHDs).	DIT-052	Y
Central Community Portal	Create a central community portal designed for use by the public to include interactive, downloadable dashboards, tools for community engagement with a data collection function, and education with a focus on Maryland-specific datasets and incorporating plain language terms to remain accessible to the public. Work alongside existing resources like the Consumer Health Information Hub.	DIT-053	Maybe; depends on data

Funding

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Grant Flexibility	Join national organizations to advocate for federal grants with longer duration and more local flexibility to better address underlying complex health factors at local and state levels. There is a critical need for more "flexibility with accountability" in the utilization of federal funds through grants and contracts.	FND-007	-
Public Health Business Advisory Board	Create a Public Health Business Advisory Board to stimulate investment in public health from the business sector. This type of investment prevents health problems such as diabetes and substance use disorders that lead to higher employer costs. As a result of preventable somatic and behavioral health problems, Maryland businesses lose significant amounts of money to workplace absences, poor productivity, and workplace errors that result in injuries and lawsuits, employee turnover, and higher health insurance premiums. Partnerships with entities like the Maryland Chamber of Commerce, academia, and local and state officials could be used to support recruitment and general needs for the Advisory Board.	FND-010	No
Charitable Foundations	Pursue strategies to identify funding from charitable foundations (coordinated by MDH, LHDs, and the Governor's Office). Public health initiatives have natural alignment with the goals of many charitable foundations and foundation grants steered by health departments may be vital to advancing community health in Maryland.	FND-021	No
MDH Grant Team	Establish a more robust MDH grant team that searches for grant opportunities for both the state and local levels and includes representatives from small and large Local Health Departments. A collaborative team can more efficiently identify grant opportunities that match with statewide public health planning and avoid duplication of efforts that would inevitably occur with 24 different jurisdictions trying to find new grants. An MDH-led team would also be able to coordinate with other state agencies (e.g., Departments of Environment, Aging, Housing, Transportation, and more) to apply for grants that go beyond traditional health boundaries.	FND-022	No
Core Funding Model Assessment	Conduct an in-depth assessment of the core funding model to ensure it adequately and equitably serves current public health needs and changing demographics since its formation in the 1990s. The proportional allocation to each local health jurisdiction, percentage of local-state match for each jurisdiction, categories of public health activities eligible to receive core funds, and any other areas will benefit from updating. The assessment will include examination of county-level funding models, service delivery activities, and the capacity to fulfill foundational public health services and the identification of successful models that can be used to inform a new funding model. The assessment will include the input of LHDs to allow more flexibility by county and provide all-party access to the formula for full understanding and transparency across the governmental system, while maintaining MDH control over allocations.	FND-054	No

Governance and Organizational Capabilities

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Co-Creation Framework Model	Maximize effective administrative and clinical public health service planning and delivery, health monitoring, and policy development through using a co-creation framework at the state and local level. This will require collaboration and integration of local health officer experience and knowledge in the development of policy positions and policy making using Maryland Department of Health's Roundtable meeting between the Public Health Services Administration and local health officers. It is also recommended that a framework for policy development and implementation be developed and implemented through consistent and equitable collaboration between state and local health departments while ensuring alignment with state laws and flexibility for local needs. This promotes coordinated system-wide data-informed planning and evaluation; strengthens system capacity through coordinated leadership and shared decision-making structures; promotes collective impact; and enhances performance management by establishing statewide and mutual accountability metrics and collaborative oversight. The Maryland State Health Improvement Plan and State Health Assessment are examples that benefit from the co-creation framework.	GOC-011	No
Academic Health Department Partnerships	Develop and support academic health department partnerships to enhance the organizational capabilities of governmental public health systems and enrich academic public health practice programs. MDH, LHDs, and academic institutions should work towards implementing academic health department (AHD) models at state and local levels that involve formal agreements with academic institutions in the state, including Historically Black Colleges and Universities (HBCUs), Community Colleges, and Graduate Medical Education programs. This effort may involve establishing an AHD community of practice in Maryland to develop template memorandums of understanding (MOUs), suggested actions that academic institutions can take to meaningfully engage with health departments, and defining standards for a well-functioning AHD model in Maryland. The effort should include partnerships with local primary care residency training programs (such as in family medicine) and medical schools for resident/student rotations in public health settings. These partnerships could create a pipeline of clinicians who understand and value public health approaches, ultimately strengthening collaboration between clinical and public health sectors. Further analysis by an AHD community of practice could resolve barriers and create expedited pathways for LHDs and the state health department to formally engage staff/faculty from academic institutions in conducting public health work for the department - including assessments, data analysis, evaluations, cost-benefit analyses, support sabbatical/details of faculty to public agencies, and providing scientific/subject matter expertise.	GOC-026	No
Social Service, Housing, Aging and Transportation Collaboration	Collaborate with state agencies that address social service, housing, and aging to better understand the needs of vulnerable populations, identify service gaps, and coordinate responses to benefit health. MDH and LHDs will examine barriers and facilitators to multi-sector partnerships at the state, regional, and local level to include problem-solving teams, "no wrong door" initiatives, assessment of policies/practices for health impacts, exploration of increased funding opportunities, and shared data systems.	GOC-027	No
Elected Official Onboarding	Develop and provide onboarding education for LHDs on how to engage with newly elected state and local public officials about public health and responsibilities, including duties of local boards of health. This will be created by LHDs, MACHO, and MDH to supplement what the Department of Legislative Affairs and the Maryland Association of Counties offer.	GOC-028	No

Private Sector Health Systems	Pursue collaboration with private sector health systems through partnerships, joint funding opportunities, research, communication, and coordination. MDH will identify barriers and facilitators of state, regional, and LHD engagement with private sector health systems. MDH will review statutory, regulatory, and administrative barriers to establishing ethical and equitable public-private partnerships for funding to and from MDH and LHDs with the private sector.	GOC-029	No
Public Health Resource Team	Establish a Public Health Resource Team, involving the new hires of 10-12 MDH staff level positions to execute the Commission on Public Health's recommendations and other related recommendations, monitor the success of changes made to the system as a result, and broker partnerships with public and private entities to leverage their expertise in developing solutions. This panel of experts/strike team can assist LHDs and MDH with emerging public health issues, public health crises, and policy development. Moreover, they could be instrumental in designing and implementing large cross-cutting public health initiatives by leveraging multiple governmental state agencies and external partners.	GOC-042	No
MDH Public Health Grand Rounds Series	Develop a MDH Public Health Grand Rounds Series to be a forum for horizontal communication across MDH departments that would allow sharing of successes of public health initiatives and successes in implementation. A Grand Rounds Series could provide a way to come together regularly around an important topic of shared interest. Invited participants could include LHDs, primary care clinicians, academicians, professional associations, elected officials, and community partners.	GOC-043	No
Listserv for LHDs	Establish and maintain a LHD listserv for specific roles within LHDs. This would facilitate communication amongst LHDs, provide opportunity to share resources and announcements, enhance communication between MDH and LHDs, and stimulate cross-jurisdictional collaboration. Ensure a routine check system and point person for regularly updating listservs with correct contacts. (MDH/MACHO leads)	GOC-044	No
Shared Governance Support	Strengthen and enhance shared governance to provide for more definition and mutual understanding between state and local partners on how best to coordinate public health planning, implementation, and evaluation of foundational and essential public health services. This model further reinforces the principle that each partner is operating with the best interests of their constituents in mind and collaboratively working with key partner state and local agencies.	GOC-052	-
LHD Accreditation	Facilitate the accreditation or Pathways Recognition status of interested LHDs by the Public Health Accreditation Board (PHAB) or other similar accreditation and pay the annual fees (MDH responsibility). Being accredited or designated as Pathways Recognized would inform local health officers and their staff of major areas to address to support quality improvement of services and operations. It also will provide a high level of assurance to the communities they serve by instilling a culture of quality improvement and excellence.	GOC-057	No
Equity Impact Assessment Policy for the Executive Branch	Establish and operationalize in State Government an Equity Impact Assessment policy to ensure health equity are central to the development, implementation, and evaluation of the promulgation and removal of regulations by Social Determinants of Health-related agencies to be defined by the Secretary of MDH when circumstances or thresholds determined by those agencies are met.	GOC-061	Yes
Equity Impact Assessment Policy for the General Assembly	Establish and operationalize in the Maryland General Assembly an Equity Impact Assessment policy to ensure health equity are central to the development, implementation, and evaluation of proposed legislation.	GOC-062	Yes

Workforce

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
Public Health Workforce Commission	Establish a multidisciplinary Public Health Workforce Commission to study, assess, and track the state and local governmental public health workforce throughout Maryland to inform workforce investments and policy decisions. The legislature should establish the commission, housed in partnership with qualified academic or research institutions, to provide strategic leadership and oversight of the state's public health workforce and its development. Establishing this commission and a standardized reporting framework will equip Maryland with the infrastructure, expertise, and data necessary to proactively address workforce challenges, build capacity, and drive equitable, evidence-based policymaking.	WKF-012	Yes
Statewide Public Health Workforce Training Strategy	Develop and implement a statewide public health workforce training strategy to ensure a well-prepared, effective, sustainable, and flexible governmental public health workforce aligned with Maryland's broader public health development goals and with a focus on professional development, advancing career pathways, expanding skills, improving job satisfaction and retention and skill development for emerging public health challenges. The legislature should allocate the necessary resources for this strategy to be developed in collaboration with academic institutions, local health departments, and other key partners, and could be led by MDH or a new Public Health Workforce Commission.	WKF-013	Yes
Maryland Responds Medical Reserve Corps Expansion	Expand and enhance local engagement for the existing Maryland Responds Medical Reserve Corps. This will require: (1) Renaming it to the "Maryland Responds Health Reserve Corps" and explicitly recruiting non-clinical personnel capable of assisting during public health emergencies, disease outbreaks, natural disasters, and other crises that strain the healthcare and public health systems; (2) Supporting more robust, locally focused and trained jurisdictional volunteer corps; (3) Ensuring dedicated funding for coordinators to work in local jurisdictions; and (4) Modernize and make more efficient the state's electronic registration system which documents and tracks volunteers. The legislature should allocate dedicated resources for this expansion and fund LHDs to recruit needed non-clinical personnel, build a more robust, locally focused and trained county-based volunteer corps, and ensure emergency public health response readiness.	WKF-014	Yes
Legal Protection of Public Health Employees	Enact legislation to protect all state and local public health employees and contractors by establishing or strengthening penalties for individuals who threaten, harass, intimidate, stalk, assault, or otherwise interfere with public health workers during their official duties.	WKF-015	Yes
Maryland Corps to Public Health Careers	Expand the existing Maryland Corps program under the Department of Service and Civic Innovation to include a dedicated public health pathway into governmental public health careers. With this change, the legislature would support a structured, service-based entry point into careers within the MDH and LHDs. With the direct input of the LHDs, this initiative would build a diverse, skilled, and mission-driven pipeline of future public health professionals equipped to meet the state's evolving health needs.	WKF-016	No

Access to Complete State Personnel Job Classifications	Grant LHDs full access to the complete range of job classifications within the state personnel system, including higher-grade classifications commonly used in other state health agencies.	WKF-037	No
Create a Dedicated Public Health Job Classification System for State and Local Health Departments	Establish a set of distinct job classification options tailored specifically to the needs of the MDH and LHD workforce.	WKF-038	No
State Personnel System Task Force Recommendations	Prioritize the timely and full implementation of the recommendations outlined in the 2023 State Personnel System Task Force report.	WKF-039	No
Study/Commission on Public Health Human Resources Reform	Authorize a comprehensive study or Commission on Human Resources Reform to strengthen LHO autonomy and explore the option of an independent human resources system for MDH, modeled on agencies like the Maryland Department of Transportation.	WKF-040	Yes
Bureau of Local Health Department Assistance and Support	Authorize the creation of a Bureau of Local Health Department (LHD) Assistance and Support in the MDH Office of the Secretary. This bureau will strengthen coordination across LHDs and to serve as a technical assistance body for the state's 24 local health departments, utilizing MACHO as a liaison. This bureau would not direct or oversee local operations but would facilitate cross-jurisdictional collaboration, elevate common challenges, and promote consistency in public health practice where appropriate.	WKF-041	No
Local Public Health Surge Volunteer Pipeline	Appoint a public health surge facilitator by MDH to assist each local health department in building their public health surge capacity. This individual would work with both the state's MRC coordinator and local health officers to support local-level efforts in recruiting and training local volunteers in public health capabilities. These volunteers will be encouraged to join MRC so that they can be officially deployed when there is a public health surge need. State level assistance can help LHDs attract and retain volunteers with communications, technology including learning management systems, and training. This will enhance both the pathway into MRC as well as the pipeline into a public health employed workforce. When necessary, the facilitator could support the MRC Coordinator in optimizing distribution of public health human resources during an emergency.	WKF-053	No
Statewide Chief Nurse Officer	Appoint a Statewide Chief Nursing Officer to provide technical assistance specific to nursing across Maryland. Nurses comprise a significant percentage of the public health workforce. This role can focus on the more than 1,000 nurses within LHDs, such as continuing education, development of policies or revising job classifications. The critical role of nurses in the leadership and delivery of public health services cannot be underestimated.	WKF-054	No

Public Comment

Recommendation Title	Recommendation Language	Reference Number	Legislative Action Need (Y/N)
MACHO Partnership	Utilize MACHO as the collective voice for all twenty-four LHDs, the liaison between LHOs as a group and MDH, and the convener and collaborator to help achieve shared MDH-LHD shared goals, strengthen the public health workforce, and promote and advocate for public health messages. MACHO will serve to facilitate interactions with other community advocacy and professional organizations to support communications, enhance collaborations and expand the scale up of successful programs.	PCP-066	No
Community, Advocacy and Professional Organizations	Formalize partnerships with statewide or national non-profit organizations by specifying the activities that align with goals of improving Maryland's population health. These include prevention and primary care initiatives such as those provided by the Maryland Academy of Family Physicians and MedChi's Episode Quality Improvement Program (EQIP), which advance public health and primary care access. Partnerships between public health and state public health and professional associations may strengthen coalition-building, workforce development and informed advocacy. State and local public health leaders should share their expertise with these associations, support the enhancement of public health or population health initiatives, such as EQIP, and find ways to meaningfully engage statewide associations or their local affiliate chapters in community health efforts.	PCP-067	No
Set of Shared Health Outcome Metrics	Create shared health and healthcare outcome metrics and goals to facilitate public health and healthcare services alignment and innovation and to jointly monitor progress.	PCP-068	No
Procurement and Contracting Efficiencies	Invest in better processes and technology systems to enhance procurement, contracting efficiencies, and contract monitoring among MDH and LHDs and hire dedicated personnel and procurement personnel to streamline processes, reduce delays, acquire resources efficiently, and monitor expenditures to support critical public health programs. (c.f. DIT-049). This recommendation will make better use of existing funding by streamlining and redesigning the procurement and contracting process.	PCP-070	No
Medicaid Reimbursement Taskforce	Establish a Medicaid Reimbursement taskforce to be convened by MACHO. The Taskforce will have representatives from MDH Healthcare Financing/Medicaid, MDH Public Health Administration, LHOs, LHD billing professionals, and MACo (Maryland Association of Counties). The taskforce is charged with collaboratively working on the following issues, in addition to other items that are determined by a majority vote to be germane. A progress report and potential legislative fixes will be submitted annually to the chairs of Maryland General Assembly House Health and Government Operations and Senate Finance Committees. Studying ways to streamline and simplify Local Health Department contracting process for insurance carriers and governmental (including master agreement negotiation, issuing normative guidance, or adopting legislation requiring carriers to enroll and credential LHDs) and making recommendations to the MDH Secretary. Studying the feasibility of restructuring Medicaid reimbursement rates for LHDs in a way that is analogous to FQHC reimbursement to better reflect the payer mix of public health agencies cost of services provided and account for the complex population needs. Exploring ways that LHDs can share in cost savings that produce measurable reductions in Medicaid expenditures as a direct result of successful public health programs. For example, reducing neonatal intensive care unit costs to Medicaid as a direct result of improved outcomes for high-risk pregnancies.	PCP-071	Yes

APPENDIX 8: SYNOPSIS OF AND COMMISSION RESPONSE TO SUBSTANTIVE OPEN COMMENTS

These recommendations are listed as they were recorded during the open comment period and may have been altered afterwards.

Communications and Public Engagement

General

Five comments emphasized the importance of sustainable capacity-building through shared services, upskilling, and flexible funding, noting that hiring public information officers (PIOs) alone is insufficient. Three comments stressed the importance of community-created, culturally relevant messaging and long-term investments in workforce resilience, including legal protections and funding to prevent burnout. Two comments highlighted the need for greater youth engagement as content creators and the importance of recognizing the impact of artificial intelligence (AI).

CPE-001 Plain Language Support

One comment recommended incorporating geographic information systems (GIS) into communication strategies. The second comment expressed support for the recommendations on plain language public health information, noting that these initiatives would significantly enhance health literacy and language accessibility statewide.

CPE-002 Language Access Support

Three comments expressed strong support for the recommendation, highlighting the critical need to improve translation and interpretation services to strengthen health literacy across Maryland's diverse communities. Commenters noted that current grant structures often require programs to outsource and fund their own translation services, which is costly, time-consuming, and sometimes delays access—especially for less commonly supported languages like Haitian Creole. One commenter emphasized that despite community members being willing to translate in-kind, reliance on contracted vendors limits flexibility and speed. Another stressed the importance of including languages beyond English and Spanish, and recommended that bilingual staff be fairly compensated given the difficulty of recruiting and retaining qualified individuals.

CPE-003: Public Feedback on Public Health Information

Two comments supported enhancing public feedback mechanisms to improve the effectiveness and trustworthiness of health communication. One comment emphasized the importance of engaging communities in two-way conversations and delivering information in ways that empower and build trust. One comment suggested using tools like ArcGIS Survey123, which integrates survey responses with mapping and demographic data, to identify areas with low engagement or understanding.

CPE-004: Public Information Officers (PIOs)

Two comments strongly supported the need for dedicated, full-time PIOs at local health departments. One highlighted that, currently, PIO duties are often assigned to already overburdened staff, limiting their effectiveness, and stressed that dedicated funding is essential to fill these roles and prioritize trust and communication. The second comment recommended standardizing communication between PIOs and population health staff to ensure consistent, community-aligned messaging that is both accurate and meaningful.

CPE-005: Health Communications Tools Modernization

Three comments emphasized the need to modernize communication infrastructure in public health. One highlighted that many systems are outdated and understaffed, making it difficult to effectively reach communities, and suggested that investing in updated systems and staff time would have a positive community impact. Another comment advocated for incorporating GIS to enable targeted, data-driven messaging that reflects Maryland's diverse demographics. The third comment offered editorial feedback on clarity and terminology in the recommendations.

CPE-018: Community Health Needs Assessment (CHNA) Support

Three comments emphasized improving coordination and tools for Community Health Needs Assessments (CHNAs) and expanding partnerships to better address youth health issues. One comment recommended including school-based health centers and institutions like Children's National Hospital as key stakeholders, especially given rising concerns around youth mental health and absenteeism. Another comment highlighted a best practice from Montgomery County and suggested that local health departments (LHDs), hospitals, and community health centers should jointly conduct CHNAs by using standardized, geospatial tools like Esri's Rapid Health Needs Assessment and CASPER methodology to improve accuracy and efficiency. Another comment proposed that, even if new funding isn't available, the Commission should encourage a coordinated CHNA approach for the Health Services Cost Review Commission (HSCRC) to adopt as a shared vision.

CPE-019: Increased Health Literacy Through Youth Education

Six comments focused on strengthening youth public health education and introducing emotional resilience programs in K–12 schools. One commenter proposed a pilot emotional resilience program aimed at addressing bullying, mental distress, substance abuse, and related social challenges, citing evidence that such programs reduce dropouts, bullying, and youth crime. Several comments proposed suggestions to fix minor errors, clarify language around "standards-aligned" curricula, and emphasize youth involvement in the task force. Input from the Maryland Department of Education highlighted ongoing efforts by the Comprehensive Health Education Standards & Frameworks Validation Committee (SFVC) to update health education standards, and recommended that the Commission align with and support the SFVC's work while advocating for minimum instructional time and clearer qualifications for health educators. Finally, the Maryland Academy of Family Physicians (MDAFP) offered to leverage its network of physicians and family medicine residents to support curriculum development, guest speaking, and near-peer education, enhancing the relevance and accessibility of public health education for students and inspiring future health professionals.

CPE-020: Health Communications Materials Dissemination Support

Two comments highlighted opportunities to improve public health messaging through data-driven communication platforms and strategic partnerships. One suggested using ArcGIS market analysis profiles to understand how residents receive information. The other comment offered the Maryland Academy of Family Physicians (MDAFP) as a collaborator to curate and disseminate health communications through their extensive network of over 1,500 family physicians statewide, utilizing newsletters, continuing education, and practice networks to ensure evidence-based information reaches trusted primary care providers.

CPE-045: Improving the Visibility of Public Health

Six comments addressed the clarity, feasibility, and potential impact of the recommendation to develop a "Maryland Public Health Issue of the Month" series. Several commenters suggested improving the wording for clarity, such as adding "by" to specify that MDH, in collaboration with academic partners, would lead the initiative. The Maryland Academy of Family Physicians (MDAFP) committed to helping disseminate this series through their communication networks, recognizing its value for healthcare providers. However, some expressed skepticism about the series' public engagement potential and suggested that it might be better integrated into communications led by a full-time PIO, if funded. Others recommended broadening the pool of expert speakers to include local, national, and international partners who could participate remotely to enrich the content. Additional suggestions included developing clear distribution pathways and partnerships (e.g., the Maryland Association of County Health Officers [MACHO]), ensuring consistent terminology regarding the Maryland Department of Health (MDH) and LHDs, and leveraging existing national communication resources to avoid duplicative efforts.

Data and Information Technology

General

There were nine general comments centered on improving public health data systems and equity. Major themes included the need to prioritize data equity and community transparency by sharing accessible, disaggregated data across various demographics such as race, disability, gender identity, and language preference, alongside supporting community data stewards and participatory governance. Several comments emphasized the ethical and strategic integration of AI and large language models to enhance data extraction, outreach, and predictive analytics, while calling for pilot programs and equity-focused guidelines. Comments also stressed the importance of streamlining data sharing across social services and community partners with secure agreements to reduce barriers and improve coordination. Additionally, commenters highlighted inefficiencies due to fragmented or inaccessible data systems like the Indicator-Based Information System (IBIS), particularly noting gaps in child health data, and called for a statewide data equity framework aligned with State Health Improvement Plan (SHIP) priorities. Some advised prioritizing recommendations based on fiscal realities and including all counties, especially hybrid and home-ruled ones, in implementation discussions.

DIT-032 Centralized Data Repository

Four comments focused on the recommendation to augment Chesapeake Regional Information System for our Patients (CRISP) as Maryland's centralized health data repository. One comment strongly advocated expanding CRISP to include comprehensive ambulatory care data from health systems and private practice electronic medical records (EMRs). Comments also called for dedicated funding to support ambulatory data

sharing with privacy protections. Commenters sought clarity on whether CRISP is intended to be the sole statewide repository and what specific issues this augmentation aims to solve. A suggestion was made to refine terminology for clarity.

DIT-033 Uniform Data Standards

One comment requested to clarify “health” versus “healthcare”.

DIT-034 Hub and Spoke Analytic Model

One comment recommended a focus on goal setting to determine what success looks like according to the Commission.

DIT-035 One State Electronic Health Record System

There were four comments addressing the recommendation around implementing a single statewide electronic health record (EHR) system. One comment asked to strengthen the language by replacing “if possible” with “at a minimum,” emphasizing the necessity for all LHDs and MDH to participate in data exchange with CRISP and other relevant systems. While there was strong support for moving toward one unified EHR system, commenters stressed the importance of gathering input from counties about their current EHRs, system strengths and weaknesses, and necessary features to allow for customization based on diverse local workflows. Some cautioned that given the diversity of health department services, prioritizing interoperability and data sharing through CRISP may be more practical and effective than mandating a single EHR system.

DIT-036 Data Use Efficiency

Two comments raised questions about the definition and purpose of “appropriate data” in the recommendation. Commenters sought clarification on whether there is consensus about what data should be shared and whether the Commission intended for data sharing primarily to demonstrate savings or return on investment across agencies. Additionally, there was an emphasis on ensuring that data sharing reduces administrative burden for all entities involved while still protecting and maintaining the relevance and privacy of patient data.

DIT-046 System Modernization

One comment suggested that instead of prescribing specific methods for improving data collection, sharing, and analysis, the Commission should focus on clearly defining the desired end goals and allow implementers the flexibility to achieve those goals through iterative problem-solving. They cautioned that rigid, long-term plans or commissions may slow progress and add bureaucracy.

DIT-047 IT and Analytics Workforce

Three comments emphasized the importance of comprehensive training that goes beyond basic data skills to include practical, hands-on experiences such as internships and thesis projects, with involvement from academic disciplines like computing technology, data science, and analysis. The critical need for paid, knowledgeable IT staff was also highlighted, along with suggestions to leverage remote work to improve cost savings, accessibility, and work-life balance, while prioritizing retention through adequate funding.

DIT-048 Digitize Public Health Records

Four comments emphasized the importance of modernizing health records with a strong focus on security to prevent data breaches, suggesting the need for robust EHR platforms and health IT specialists to build patient trust. Several commenters stressed that digitization should be user-friendly, simple, and concise, and highlighted the need for dedicated, possibly contracted, staff to handle the labor-intensive transition without overburdening existing employees. An incremental, research-driven approach was recommended over wholesale digitization, with clear goals around cost and space impacts. Finally, adherence to existing state record retention policies was noted.

DIT-049 Business Systems

Four comments addressed the recommendation, noting the need to clarify what "systems" specifically refers to. Commenters suggested the Commission focus more on the desired outcomes—such as cost savings, easier staff mobility, and improved reporting efficiency—rather than prescribing specific methods.

DIT-050 Environmental Health Systems

Two comments expressed strong support for increased investment in IT systems and workforce related to environmental health data, with a suggestion to broaden the scope beyond just licensing and complaints, given the significant impact of environmental conditions on health. Commenters recommended clarifying how the recommendation will specifically contribute to accountability and performance management, and suggest restating it to focus on desired outcomes while allowing agencies like MDE, MDH, and LHDs to collaboratively and adaptively work toward those goals.

DIT-051 Enterprise Architecture

One comment noted that architecture should include interoperability with EHRs in the healthcare delivery system.

DIT-052 Dedicated Funding for Technology

Two comments raised questions about the proposal for dedicated funding, asking specifically which problems this funding aims to solve and how it can be secured during tight budget periods without adding administrative overhead. Additionally, there was confusion around the term "CORE," questioning whether it refers to existing core funding or a new funding source.

DIT-053 Central Community Portal

Five comments supported the idea of an open data portal, highlighting successful models from other states and emphasizing the importance of integrating EHR data and other survey sources to avoid duplication. One comment noted the critical role of GIS. Comments suggested the portal should enable real-time tracking and predictive analytics, leveraging existing platforms to improve data integration and usability. However, there was a strong recommendation to reframe the proposal by focusing on desired outcomes and user needs, rather than prescribing the creation and maintenance of a new costly portal, ensuring the public-facing information is accessible and understandable to all.

Funding

General

Approximately seven general comments were made around funding for public health. Four comments focused on sustainable, transformative financing models beyond short-term grants, recommending blended funding, outcome-based strategies, and innovation funds. Three comments highlighted the need to modernize the core funding formula with equity at the center, including community engagement and rewarding preventive interventions. Three comments focused on incentivizing local flexibility and innovation, such as supporting community health workers and cross-sector partnerships. Two comments mentioned administrative burden reduction through shared infrastructure and simplified reporting.

FND-025 Medicaid Rebates to Public Health Agencies

One comment expressed support of this recommendation, but noted the importance of funding support for LHDs to ensure they are able to bill and collect money effectively.

FND-007 Advocacy for Federal Grants with Longer Durations and More Local Flexibility

One comment expressed support and shared personal experience with difficulties on maintaining funding for projects.

FND-010 Public Health Business Advisory Board

Two comments highlighted the importance of broadening advisory board recruitment by engaging key partners beyond traditional public health circles.

FND-022 MDH Grant Team

Three comments were made on the challenge of mismatched staff hours versus grant funding, with a strong recommendation for CORE grant funds to cover salaries and benefits, allowing more flexible staff allocation across programs and reducing administrative strain. Another comment supported establishing a dedicated grant team, possibly funded by local philanthropies or coordinated with Medicaid Managed Care Organizations, to enhance grant opportunities and sustainable funding. Additionally, GIS technology was highlighted as a tool for identifying eligible grants.

FND-025 Medicaid Rebates to Public Health Agencies

Three comments expressed strong support for the effort to capture healthcare savings resulting from public health interventions, viewing it as an innovative funding approach with potential for broader application beyond Medicaid. However, concerns were raised about attribution challenges, emphasizing the need for clear metrics that fairly recognize the collaborative contributions of local health departments and primary care providers to avoid competitive dynamics or misattribution of credit. Additionally, there was some confusion regarding the “Medicaid rebates to public health agencies” concept.

FND-054 Revisit Core Funding Formula

Four comments emphasized the need to modernize Maryland’s core funding formula for LHDs, stressing transparency, predictability, and flexibility tailored to individual county needs. Commenters highlighted

concerns that current funding is often one-size-fits-all and lacks clarity—particularly around local matching contributions, which have caused unexpected financial strains for some counties. There was broad support for involving LHDs in funding decisions through inclusive, multi-sector steering committees, modeled after approaches used in Washington State, to enhance collaboration while maintaining state control over allocations. Additionally, commenters urged that the formula revision consider evolving public health demands, potential regionalization of LHDs, and clearer communication to strengthen the state-county partnership and ensure sustainable budgeting.

Governance and Organizational Capabilities

General

Approximately four commenters offered general support or noted that the recommendations as written helped advance public health in the state. Two noted that while the recommendations were good, the fiscal climate makes their implementation less clear. One commenter noted that the term "Local Health Officer" should be used consistently throughout.

GOC-026 Academic Health Departments

Several commenters expressed support for GOC-026/Supporting and Developing Academic Health Partnerships. It was noted that this should include community colleges, and have a specific curriculum that encourages hands-on and real-world applications in addition to academic exercises. Commenters also noted the need to reinforce equity and reciprocal benefits between local communities and academic health departments (AHDs). Another commenter noted that there needed to be more expedited pathways for LHDs to leverage expertise of higher education through evaluations, program design, etc. One commenter suggested that LHDs prioritize partnerships with Family Medicine programs to facilitate the connection between clinical residents and public health practice through the AHD model.

GOC-011 Co-creation Framework and GOC-052 Shared Governance

Multiple commenters noted the relationship and interdependence of these recommendations. Co-creation generated several comments, noting that more specificity was needed and the language was confusing or unclear. Others noted they were pleased to see other entities, including other state agencies, specifically called out in the shared governance and co-creation frameworks. One commenter noted that GOC-052 could be more streamlined in its introduction and that MACHO could help with some of these activities contemplated by these recommendations. In particular, the feedback noted models such as Washington State, where the funding and governance are more outcomes-oriented and less prescriptive in statute. Several comments included specific aspects that were not reflected in the recommendations:

- Promote accountability by using metrics, feedback mechanisms, and escalation pathways
- Increase engagement at multiple levels within MDH/LHD to ensure consistent messaging and awareness, particularly around key programs and strategic plans
- Leverage tools and software to integrate and share data and metrics in multiple ways, including maps and visual aids
- Reflect community voices in the governance model, either through local boards of health or other mechanisms, including paid engagement opportunities

- Ensure alignment between Government and Organizational Capabilities (GOC) and Workforce (WKF) recommendations to fully and holistically address the issues/challenges.

GOC-027 Social Service, Housing, Aging and Transportation Collaboration

One commenter supported the recommendation, but noted funding is needed to increase services delivered by these agencies; specifically, the barriers have already been studied and additional analysis is not needed.

GOC-028 Enhance Understanding of Public Health

One commenter noted work is underway to develop this toolkit for local health officers (LHOs) to be able to deliver to their community elected officials.

GOC-029 Partnering with Private Health Systems and the Private Sector

One commenter expressed concern about the perceived outsourcing of public health functions. One commenter noted that guardrails were needed to ensure public benefit remains priority with strong transparency and evaluation mechanisms rooted in equity.

GOC-042 Public Health Resource Team

One commenter noted it would be useful to understand more about these individuals and where they would be housed or funded.

GOC-043 MDH Public Health Grand Rounds

Two commenters noted that adding partner organizations like the Maryland Academy of Family Physicians (MDAFP) (specifically named) would help promote collaboration and deepen awareness of multi-sector issues. Another commenter noted that bringing in national or regional experts would enrich the series and convey its importance.

GOC-044 LHD Listserv

One commenter supported the recommendation, but noted that something more robust was needed, specifically highlighting challenges with updating information/recipients. Such a tool should emphasize multiple areas of interest and communities of practice within LHDs across the state (e.g., PIOs, infectious disease clinicians, etc.). One commenter noted MACHO could be utilized to facilitate this.

GOC-057 LHD Accreditation

One commenter noted the importance of LHDs being accredited and engaging in performance management so they have the capacity to serve their communities. Two commenters emphasized the importance of Public Health Accreditation Board (PHAB) accreditation. They separately suggested Maryland should follow the lead of other states, such as Ohio, to require accreditation of all LHDs while providing the funding and assistance to do so.

GOC-061 and GOC-062 Equity Impact Assessments for Executive Branch and the Maryland General Assembly

Several commenters expressed support for the recommendations and their underlying intent. One commenter noted that these recommendations might have the opposite effect of what they intend by potentially being discriminatory and intrusive.

Workforce

General

Across approximately six general comments, major themes emphasized the urgent need to invest in public health workforce retention and development beyond just recruitment, highlighting strategies like tuition reimbursement, leadership pathways, mental health supports, and addressing compensation and burnout. Equity was also a key focus, with calls to prioritize recruitment and advancement of staff from underrepresented communities, formally include community health workers, and embed equity in training. Several comments stressed elevating the role of nurses and mid-level providers through leadership authority, education funding, and recognition of their critical community roles. The importance of leveraging technology and innovation—such as AI literacy, pilot programs, and hybrid work—is also noted. One comment highlighted the need for better community connection and coordination among local organizations to ensure residents are aware of and can access available services, proposing a shared resource system to improve emergency response and reduce duplication. One comment mentioned that emergency preparedness is critical given climate change. Several comments also urged that these efforts be paired with sustained funding and supportive work environments to prevent burnout.

WKF-013 Develop and Implement a Statewide Public Health Workforce Training Strategy

In one comment, it was suggested that MDH should develop and implement training programs focused on ArcGIS, particularly its no-code tools like Story Maps and Hub sites.

WKF-014 Provide Grants to Local Health Agencies to Maintain and Strengthen Health Reserve Corps to Ensure Emergency Public Health Response Readiness

Three comments supported the importance of both medical and non-medical Maryland Medical Reserve Corps (MRC) volunteers, with an emphasis on having dedicated, funded coordinators to support these efforts. Suggestions included expanding local volunteer programs beyond county lines into regional collaborations (e.g., a Mid-Shore region combining several counties) and improving volunteer registration, documentation, and tracking systems—ideally integrating these into larger state data modernization initiatives like EHR systems. Additionally, it was noted that many non-clinical volunteers, such as epidemiologists and lab professionals, could provide valuable remote support during emergencies, especially given Maryland's need to independently develop guidance amid reductions in CDC staffing. One comment also highlighted the potential of ArcGIS software to visualize workforce distribution and identify staffing gaps statewide.

WKF-015 Strengthen Legal Protections for Public Health Employees Through Enhanced Penalties for Threats, Harassment, and Acts of Violence

Two comments expressed their support of this recommendation and its importance.

WKF-041 Establish a Bureau of Local Health Department Assistance and Support

One comment emphasized the importance of including MACHO as a key partner and liaison. Another comment agreed that while creating such a bureau would provide needed personnel support for LHDs, this function should remain within the Public Health division rather than being placed under the Office of the Secretary, as separating oversight from support could be counterproductive.

WKF-053 Appoint a Statewide Volunteer Coordinator for Emergency Preparedness

There were four comments related to this recommendation. One suggested collaborating closely with existing disaster volunteer groups—both faith-based (like Eight Days of Hope and Baptist Disaster Response) and non-faith-based (such as Team Rubicon)—noting these groups often use Federal Emergency Management Agency (FEMA)-certified incident command structures, which could enhance coordination and shared goals. Another comment emphasized the importance of hiring and training such coordinators before emergencies occur to avoid scrambling. The value of incorporating remote volunteers to serve diverse geographic areas was also highlighted. A comment from the Maryland Department of Emergency Management (MDEM) noted that they already coordinate volunteer resources statewide through existing policies, procedures, and dedicated staff, suggesting that creating a separate statewide volunteer coordinator might duplicate current efforts.

WKF-054 Appoint a Statewide Chief Nursing Officer

One comment expressed strong support and need for this recommendation.

Cross-cutting Recommendations

General

There were six general comments made. Three comments focused on improving administrative and workforce capacity. Another major theme was enhancing Maryland's autonomy in public health science by independently evaluating federal policies and tailoring science-based recommendations locally. Two comments suggesting leveraging private-sector value-based care models, especially physician-led programs like Medchi's Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPCP), were highlighted as a way to improve outcomes and reduce costs. One comment suggested addressing climate change's health impacts within the Commission's recommendations.

CCR-055 Placing Public Health Navigators in the Community

Across two comments, there was strong support for expanding the role of public health navigators beyond traditional public shopping districts, especially in areas where such districts are limited. Suggestions included placing navigators in schools, food banks, and Federally Qualified Health Centers (FQHCs), and deploying mobile units to meet people at community events, thereby improving follow-up and direct access to resources. One comment recommended leveraging Esri's ArcGIS site-selection and demographic tools.

CCR-056 Primary Care Support

Across three comments, there was a clear emphasis on addressing primary care shortages and improving access, particularly noting long wait times of three to nine months for new patient appointments. Telehealth expansion is seen as a helpful, though not comprehensive, solution to overcome transportation and access barriers. The National Association of Community Health Centers (NACHC) and its Chief Health Officer were suggested as potential partners to support programs like the Teaching Health Center Program, which helps retain primary care practitioners in communities after training. Additionally, the MDAFP expressed a strong interest in contributing to the development of incentive programs for primary care clinicians, offering valuable insights to tackle workforce challenges, sustain practices, and align recruitment strategies with public health goals.

CCR-058 Assessing and Strengthening the Public Health Laboratory System

One comment recommended including new technologies into Maryland's public health laboratory system.

CCR-063 Health Improvement Funds

One comment suggested using ArcGIS technology to support the Population Health Improvement Fund. One comment asked for formal representation or ongoing input in the fund's governance by the MDAFP, highlighting family physicians' critical role in population health management and preventive care.

CCR-064 Governmental public health foundational services and behavioral health services

One comment suggested using ArcGIS software to analyze, visualize, and predict where services can be better coordinated. One comment asked to clarify and improve coordination between the Behavioral Health Administration and LHDs, recommending better integration of preventive and early intervention behavioral health services—such as suicide prevention and harm reduction—into LHDs where not yet implemented. One comment recommended streamlining oversight and regulatory functions through consistent mechanisms to reduce system complexity and enhance service delivery at the county level.

CCR-065 Public Health and Primary Care Continuum

One comment claimed that this recommendation is not needed and would dilute the mission of LHDs.

APPENDIX 9: DETAILED ASSESSMENT METHODOLOGIES

In support of the Maryland Commission on Public Health (the Commission), the assessment team, which comprises academic partners from the University of Maryland School of Public Health and the Morgan State University School of Community Health and Policy, gathered and synthesized information from a wide variety of sources to assess Maryland's foundational public health capabilities and its ability to respond to public health challenges. This appendix details the methodologies used for the qualitative interviews, focus groups, and organizational survey.

The academic partners from Coppin State University contributed both methodological and subject-matter expertise to the development of the organizational survey, and key informant and focus group instruments; provided assessment advisory support and facilitated linkage with core external organizations and stakeholders to be interviewed; supported final reviews of the assessment instruments; and led the creation of the Commission's conceptual model.

Qualitative Interviews

Sampling Frame

The entities specified in the legislation that created the Commission, along with other entities of interest to Commission members, first developed a list of individuals to consider for qualitative interviews. Commission co-chairs, workgroup co-chairs, and workgroup members then reviewed this list several times. The list grew and evolved as the Commission's work revealed the need to explore specific components of the public health system.

Final Sample

The assessment team conducted 76 interviews with 104 individuals from October 2024 through February 2025. The final set of participants included leadership from all 24 local health departments (LHDs), as well as the Maryland Department of Health (MDH), who were asked questions about their capacity to fulfill the foundational public health capabilities, their successes and challenges, as well as their ideas for the future of the public health infrastructure in Maryland. They also conducted interviews with elected state and county officials, as well as leaders of state-level agencies, commissions that address health-related issues, advocacy groups, and health-related associations, to gain their perspectives. A list of entities and organizations represented in the interviews is included below:

Entities Interviewed

Local Health Departments

Allegany County Health Department
Anne Arundel County Health Department
Baltimore City Health Department
Baltimore County Department of Health
Calvert County Health Department
Caroline County Health Department
Carroll County Health Department
Cecil County Health Department
Charles County Department of Health
Dorchester County Health Department
Frederick County Health Department
Garrett County Health Department
Harford County Health Department
Howard County Health Department
Kent County Health Department
Montgomery County Department of Health and Human Services
Prince George's County Health Department
Queen Anne's County Health Department
Somerset County Health Department
St. Mary's County Health Department
Talbot County Health Department
Washington County Health Department
Wicomico County Health Department
Worcester County Health Department

Advocacy Organization & Healthcare Associations

Chesapeake Regional Information System for our Patients (CRISP)
Maryland Assembly on School-based Health Care
Maryland Association of Counties
Maryland Association of County Health Officers
Maryland Dental Action Coalition
Maryland Health Care Commission
Maryland Hospital Association
Maryland Nurses Association
Maryland Public Health Association
Maryland Rural Health Association
Maryland State Dental Association
Maryland State Medical Society (MedChi)
Mid-Atlantic Association of Community Health Centers
University of Maryland Medical System

Maryland Department of Health

Cancer and Chronic Disease Bureau
Center for Injury and Violence Prevention
Healthcare Financing and Medicaid
Maryland Community Health Resources Commission
Maryland Primary Care Program Office
Maryland Responds Medical Reserve Corps Network
Maternal and Child Health Bureau
Office of Contract Management and Procurement
Office of Enterprise Technology
Office of Human Resources
Office of Minority Health and Health Disparities
Office of Population Health Improvement
Office of Preparedness and Response
Office of Prevention and Health Promotion
Primary Behavioral Health & Early Intervention
Public Health Services Administration

State Departments and Agencies

Department of Aging
Department of Agriculture
Department of Budget and Management
Department of Disabilities
Department of Education
Department of General Services
Department of Labor
Department of Occupational Safety and Health
Department of the Environment

Elected Officials & Local Government Leadership

Anne Arundel County
Baltimore County
Calvert County
Cecil County
Frederick County
Howard County
Prince George's County

Interview Questions

Because the intent of the interviews was to encourage candid conversations about participant perspectives and experiences, the assessment team developed a set of question probes that could lead to meaningful dialogue. Different types of individuals were asked questions related to their roles, responsibilities, and knowledge, resulting in qualitative interview guides for five categories of respondents (LHD leadership, MDH leadership, leadership from other state-level departments and agencies, leadership from advocacy organizations and healthcare associations, and elected officials/local government leadership). These probes were developed in collaboration with Commission leaders and workgroup members and reviewed several times as feedback was obtained. The interviews were designed to last no longer than one hour and were conducted by either Zoom or telephone by one of two members of the assessment team, each of whom has a doctoral degree and longstanding experience in the public health field.

Example questions for each category are provided below by respondent type. The specific questions asked in each interview depended on the interviewee's role and the direction the interview took. The interviews focused on questions about Governance and Structure, Workforce, Partnerships, Funding, Data and IT Infrastructure, Communication, and Vision for the Future, with questions on health equity embedded throughout.

Local Health Department Leadership

Governance and Structure	Workforce
• Can you please describe how your local health department is organized to fulfill the foundational public health capabilities? • The CDC categorizes Maryland's public health structure as a "shared model," with support and responsibilities shared between state and local governments. Maryland's system of public health governance has resulted in variation in the size, scope, and budget of local health departments, despite sharing some consistent core programs. In your opinion, how is this model working? • What aspects of your health department's governance structure and norms contribute to the success of your department?	• How would you describe the ability of your health department to recruit, develop, and retain the workforce needed to execute your health department's foundational capabilities? • What gaps presently exist in your workforce in terms of delivering the foundational public health services? How are you working to fill those gaps? • What sources or pipeline programs are most useful for candidate recruitment? • What experiences have you had with academic institutions in Maryland in terms of developing a pipeline for the workforce? • How does your health department work to build an equitable workforce?
Partnerships	**Funding**
• Can you describe some key partnerships that exist between your health department and other local agencies and community-based groups? What about partnerships with MDH or other state-level entities? • How do partnerships play a role in equitable access to public health services? • What do you think others can learn from your experiences partnering with entities?	• To what extent are you able to fund both your department's work in the foundational public health areas as well as other high priority initiatives? • Could you give your impression of the equity in the distribution of health funding for communities, either in general, or specifically at your LHD? • What administrative impediments exist regarding funding high priority initiatives or programs?

Data and IT Infrastructure	Communication
• What are some specific areas of assessment and surveillance needing improvement? • How do you use data to inform your decisions and planning? • How does data use and the data infrastructure impact health equity, for better or for worse? • What aspects of the existing data infrastructure promote your ability to operate efficiently?	• What are some of the "lessons learned" in terms of the best ways to engage with the public (e.g., share information and obtain meaningful input)? • What strategies do you use to maintain internal communications so that all the relevant groups within your health department are aware of what they need to know? • How do you embed efforts towards achieving health equity into your communications strategies?
Readiness	**Vision for the Future**
• To what degree do you feel your health department is ready to execute an emergency response? • Could you speak to how health equity is considered in your department's emergency response preparations? • In your opinion, what were the key "lessons learned" in terms of what went well and what did not during the COVID-19 experience? • What are some of the advantages of the current system in terms of readiness and emergency preparedness? What about disadvantages?	• Finally, can you tell me about your vision for the future for your health department? • What recommendations do you have—or what changes would you like to see—to improve your health department's ability to implement foundational public health services? • What about recommendations that extend beyond your locality—what changes would you like to see to improve Maryland's ability to promote and protect the health of the public?

Maryland Department of Health Leadership

Governance and Structure	Workforce
• Can you please describe how MDH and/or your [office/agency/administration] within MDH is organized to fulfill the referenced foundational capabilities? • In what ways, if any, does the existing governance structure and norms of your [office/agency/administration] impede your ability to implement foundational capabilities? • Are there ways in which your [office's/agency's/administration's] governance structure and norms support or impede advancing health equity?	• How would you describe MDH's ability to recruit, develop, and retain the workforce needed to execute its core activities/programs/foundational capabilities? • How does MDH work to build an equitable workforce? • What sources and/or pipeline programs are most used for candidate recruitment? • In what ways do you think partnerships between academic institutions and governmental public health entities can be improved and sustained?

Partnerships

- Can you describe some key partnerships that exist between MDH and/or your [office/administration/agency] and other state-level entities or organizations?
- What about local health departments?
- What about national agencies, such as the CDC?
- How do these partnerships support your efforts in covering the foundational public health areas?
- In what ways do you see partnerships as important to achieving health equity? How do partnerships play a role in equitable access to public health services?
- What have been some of the outcomes of these partnerships, either positive or negative?

Funding

- To what extent are you able to fund both your work in the foundational public health areas and high priority initiatives?
- What is your impression of the equity in the distribution of health funding for communities?
- To what extent are external grants used to fund your department's activities? What is your capacity to apply for grants?
- What is your impression of any joint decision-making between MDH and MACHO regarding federal grant distribution and the development of the Core Funding formula?
- What administrative impediments exist regarding funding high priority initiatives or programs?

Data and IT Infrastructure

- What aspects of the existing data/IT infrastructure promote your ability to operate efficiently?
- What are some specific areas of assessment and surveillance needing improvement?
- How does data use and the data infrastructure impact health equity, for better or for worse?
- How would you describe the data-to-action pipeline in the work of your [office/administration/agency]?

Communication

- What strategies do you use to maintain internal communications so that all relevant groups within MDH are aware of what they need to know about the work of your [office/agency/administration]?
- How do you embed efforts towards achieving health equity into your communications strategies?
- How would you describe communication between MDH and the local health departments?

Readiness

- To what degree do you feel MDH and/or your department is ready to execute an emergency response?
- Could you speak to how health equity is considered in your emergency response preparations?
- What are some of the advantages and disadvantages of the current system in terms of readiness and emergency preparedness?

Vision for the Future

- Finally, can you tell me about your vision for the future for MDH and your [office/agency]?
- What changes would you like to see to improve Maryland's ability to fully implement the foundational public health services?
- What do you consider to be most important moving forward in efforts to achieve health equity?

Head of State Department/Agency

Perspectives on Public Health in Maryland

- Do you have any general perspectives you'd like to share on the public health infrastructure in Maryland—any impressions of what we do well, or where there's room for improvement?
- What do you see as the role of governmental public health agencies, and how is that similar or different from your organization's role in public health?

Governance and Structure

- What connection do you see between the mission of your department and the work of the public health agencies in Maryland?
- What are your current priority efforts related to public health for your department?
- What is the nature of interactions regarding public health issues between your department's leadership team and those of MDH?

Partnerships

- Can you give an example of a recent partnership with MDH?
- What about a similar initiative with a local health department that you can describe?
- Are there joint efforts between your system and public health agencies which you would like to expand in the future?
- In what ways do you see partnerships as important to achieving health equity?

Communication

- Can you provide some examples of public health topic areas that you believe are important to communicate about to your priority populations?
- What do you see as the most effective methods that your agency uses to communicate with community members about those issues?
- Could you talk about how health equity is considered in your communications?

Funding

- Could you give your impression of how and how much health equity is considered in your department's funding? Could you give your impression of the equity in the distribution of health funding for communities?
- How do you think funding could be allocated to better address the public health related needs of the Marylanders served by your department?

Data and IT Infrastructure

- What issues related to data infrastructure and information technology are important to consider for achieving our goal of improving the health of the population in Maryland?

Vision for the Future

- Finally, can you tell me about your vision for the future of your department as it relates to meeting the foundational public health capabilities?
- What changes would you like to see, if any, to improve Maryland's ability to promote and protect the health of the public?
- What efforts do you consider to be most important in moving forward to achieve health equity?

Advocacy Organization/Health Care Association Leadership

Understanding Priority Areas

- Can you describe your organization's activities related to public health?
- Can you provide some examples of public health priority areas that you believe are important?

Communication

- What methods do you use to communicate with community members about those issues?
- How would you describe the communications between governmental public health entities and your organization?

Partnerships

- How do you see access to and linkage with care/clinical services currently working? Are there ways this could be best established or improved?
- In what ways do you see partnerships as important to achieving health equity?
- What sorts of partnerships, if any, exist between your organization and MDH?
- What about with local health departments or public health-oriented community groups?

Data and IT Infrastructure

- What issues related to the public health data infrastructure and information technology are important for us to consider?
- How would you describe the data sharing between public health agencies and clinical providers?
- How has your organization used CRISP?

Funding

- How do you think funding could be allocated to better address the foundational public health services for Marylanders?

Workforce

- What are your thoughts about the public health workforce in Maryland?
- What are some suggestions for improving the capabilities of the workforce?

Vision for the Future

- Can you describe some areas for improvement related to the public health system in Maryland?
- How do you think progress could be made in those areas?
- State legislative initiatives and local policies can influence public health, in good and not so good ways. Can you tell me about health policies that are critically important moving forward to help your organization to achieve its goals?
- What do you consider to be most important moving forward in efforts to achieve health equity?

Elected Officials/Local Government Leadership

Understanding of Public Health

- How would you describe your knowledge of public health prior to you assuming your current role?
- How has your understanding and familiarity with public health evolved during your time as a [position]? What was influential in shaping your understanding?
- Where would you prioritize public health among other issues?

Workforce, Data and IT, Funding

- Are you aware of gaps in the public health workforce in your jurisdiction? If yes: What strategies might help fill these gaps? If no: How might we help legislators understand the critical importance of the public health workforce?
- What issues related to data or IT within the public health infrastructure have come to your attention?
- How are funding allocation decisions typically made regarding public health issues?

Serving Constituent Needs

- How do you learn about the health needs facing your constituents?
- Are you familiar with any recent community health assessments and or community health improvement plans? What recommendations did those assessments/plans have for your jurisdiction?
- Have efforts to achieve health equity for your constituents come to your attention? In what ways?
- What are your thoughts on how public health information is communicated with the public?
- We understand that you have to balance multiple priorities when making decisions. We are curious if requests made to you to enact public health initiatives might sometimes seem unrealistic or not feasible. If so, how can we make our public health recommendations more actionable, especially when competing with other areas for funding and attention?

Governance and Structure

- The CDC categorizes Maryland's public health structure as a "shared model," with support and responsibilities shared between state and local governments. This has resulted in variation in the size, scope, and budget of local health departments, despite sharing some consistent core programs. Do you think there should be more consistency between local health departments, or is variation between jurisdictions useful?
- What are your views, if any, regarding regionalization of public health resources?
- MDH is a "super-agency" with several major components, including Public Health, Developmental Disabilities, Health Care Financing/Medicaid, and Behavioral Health in the same agency under one Secretary. Most other states administer these functions as multiple agencies. What do you think are the advantages and disadvantages of how public health is organized at the state level in Maryland?

Vision for the Future

- What changes would you like to see, if any, to improve Maryland's ability to promote and protect the health of the public?
- How do you think progress could be made in those areas? What does the path forward look like?
- What do you consider to be most important for moving forward in efforts to achieve health equity?

FOCUS GROUPS

Purpose

Twelve virtual focus groups were conducted to collect more detailed information on key topic areas. The focus group topics were generated by the Commission co-chairs and developed with extensive input and review from the Commission co-chairs and the workgroup co-chairs. The final focus group topics were:

- Academic Partnerships
- Assessment and Surveillance
- Behavioral Health
- Chronic Disease
- Communicable Disease
- Communication and Public Engagement
- Environmental Health
- Human Resources
- Injury and Violence Prevention
- Maternal and Child Health
- Public Health Emergency Response and Preparedness
- Public Health Nursing

The focus groups, each lasting one hour, took place by Zoom between November 2024 and January 2025.

Participants

The focus group participants were identified in two ways. First, for topics that had an established ad hoc group of LHD personnel through the Maryland Association of County Health Officers (MACHO), group members received direct invitations to participate in the appropriate focus group. Second, for topics where there was no established ad hoc group, Health Officers received a form to nominate staff members within their LHDs for participation. Invitations to register were then sent to the nominated LHD employees to participate in the scheduled focus group. For any group that registered more than 15 participants, a selection of participants was approved to participate in order to ensure geographical diversity.

Information Collected

Similar to the interviews, the focus groups discussed successes and challenges, as well as the participants' ideas for the future.

Focus Group Facilitator's Guide

A Facilitator's Guide was prepared for each of the 12 virtual focus groups. These guides were created in collaboration with Commission workgroup members and included discussion questions that tapped into the specific expertise of focus group participants. Example questions from those guides are provided below. These examples do not encompass all questions or the ways in which questions were adapted during the session to meet the needs of the discussion and the present group. The central questions, while not asked directly to participants, are meant to capture the priorities of that focus group.

Academic Partners

Central Questions	Example Discussion Questions
• How do/can academic partners best support and partner with Maryland's governmental public health? • For academic partners who are partnering, or have attempted partnering with local or state health departments, what has worked well, what can be improved?	• What mechanisms exist today for sharing information about educational offerings among the academic partners in Maryland? With governmental public health? • What skillsets do you feel are essential for graduates of your programs to have to manage contemporary public health challenges? • Please describe any programs, collaborations, or arrangements between your academic institution and state or local governmental public health departments in Maryland. What has worked well? What can be improved? • What have been some of the major challenges in promoting governmental public health practice work as a career in public health to your students? • What are some ideas to increase the pipeline of undergraduate or graduate public health students into the local or state public health workforce? • To what extent do your academic institutions offer continuing education opportunities for people established in the public health workforce?

Assessment and Surveillance

Central Questions	Example Discussion Questions
• What are the strengths and weaknesses of Maryland's current assessment and surveillance activities related to public health? • How are assessment and surveillance outcomes used to inform local health department planning and program implementation? • How modern and coordinated are the necessary data systems to fulfill this foundational capability? • What system level changes are needed to strengthen Maryland's current assessment and surveillance capabilities?	• Can you share one of your top challenges related to assessment and surveillance? Referencing a challenge that appears more than once in the chat: Can anyone share more about how that challenge impacts your work and what improvements you would like to see? • How could timely health status data and trends be better highlighted and communicated to the public, elected officials, community partners? How can the data be better utilized to influence policy makers? • How are you addressing challenges in terms of health equity? How do you ensure that the strategies are culturally appropriate for the priority populations? • What are the highest priority recommendations for improving data infrastructure capabilities in Maryland? • What suggestions do you have to ensure that assessment and surveillance data resources/ systems are accessible to all local health departments to act and respond in real time? • What could be improved to reduce barriers or challenges you experience related to pulling data or tracking data both internally and to external partners?

Behavioral Health

Central Questions	Example Discussion Questions
• How do the foundational health capabilities in Maryland support the continuum of substance use prevention, early intervention, addiction treatment, and overdose prevention? • How do those capabilities support wellness promotion, mental health screening, early intervention for mental health conditions, and comprehensive care for individuals with mental health disorders?	• How would you describe your agency's balance of activities related to prevention, early intervention, addiction treatment, chronic care management? And is that balance working? • How are you addressing challenges in terms of health equity? How do you ensure that the strategies are culturally appropriate for the priority populations? • What appears to be working well related to how our public health agencies and local behavioral health authorities engage behavioral health care system partners? What could be improved? • In terms of your workforce, are there system changes that if made could strengthen your ability to recruit, develop, and retain your workforce? • In what ways do funding challenges impact your ability to deliver behavioral health services?

Chronic Disease Prevention

Central Question	Example Discussion Questions
• How do the foundational public health capabilities at the local level affect our ability to address the risk factors that give rise to chronic diseases? • Note: Chronic diseases of interest include diabetes, cardiovascular disease, cancer, dental diseases including oral cancers, cognitive decline, and chronic mental health conditions.	• Thinking back over the past ten years, are the chronic disease prevention strategies that were most successful in the past still effective? If not, what changes are needed for you to be effective in addressing chronic disease? • Chronic disease prevention challenges could take place in surveillance and data collection, communications, partner collaborations, and programs and policies. In which of these areas have you made the most or least progress? • What barriers do you face in your work with respect to addressing health equity as it relates to chronic disease prevention? • How can the utilization of EHRs in Maryland, or your county, be optimized for chronic disease prevention and management? • Are there any specific programs related to chronic disease prevention or management that are underfunded relative to their importance?

Communications

Central Questions	Example Discussion Questions
• How effectively are clear communications functioning as a foundational public health capability? • What system level changes are needed to strengthen Maryland's current communications capabilities?	• On a scale of 1 to 10, with 1 being the least trained and 10 being the most trained, how would you rate the public health workforce's ability to communicate effectively with the public? Why did you rate it as such? • In a public health emergency, communications with local, state, and national agencies, as well the public, are crucial. What are your perspectives on what's needed to strengthen the current communication systems? • How can the relationship between MDH and local jurisdictions, or between local jurisdictions, be strengthened to improve health-related communication efforts? • What strides have been made in closing the digital divide in Maryland or in reducing any impact of the digital divide? • In your experience, what are the main barriers to effective communication with diverse populations about key public health challenges (e.g., COVID-19, overdoses, maternal and infant mortality, mental health, etc.)?

Communicable Diseases

Central Questions	Example Discussion Questions
• How do the foundational public health capabilities at the local level affect our ability to monitor, respond to, and prevent communicable diseases? • Note: Communicable diseases of interest include HIV, COVID-19, flu, Mpox, and STIs.	• Where are the strengths and weaknesses of the current data systems in terms of timeliness, accuracy, and completeness of surveillance and case reporting? • How can the utilization of EHRs in Maryland, or your county, be optimized for chronic disease prevention and management? • Where are the biggest workforce issues or gaps you see in your work? How can those issues or gaps be improved? • How could the timeliness of communications be improved between health entities as it relates to prevention and management of infectious diseases? • Thinking of health equity and communicable disease, which social drivers of health most impact your efforts to address communicable diseases? • What do you need to feel prepared for future infectious disease events such as clusters or outbreaks?

Environmental Health

Central Questions	Example Discussion Questions
• How do the foundational public health capabilities at the local level affect our ability to follow regulations and monitor environmental conditions to protect the public from environmental concerns?	• Thinking across environmental health (e.g., sewage disposal, vector-borne diseases, food protection, etc.), which areas do you feel are strongest, and which are the weakest? • What is your organization's biggest challenge in regulating and enforcing state and local environmental health regulations, laws, and ordinances? • Let's discuss the shared governance between MDH, MDE, local health departments, and other local entities. How could this shared oversight better support your environmental health efforts? • What is needed to improve the pipeline of environmental health specialists? Are there any other workforce gaps or shortages? • How are you addressing challenges in environmental justice and health equity?

Human Resources

Central Questions	Example Discussion Questions
• What is needed to optimize the processes to recruit, develop, promote, and retain a diverse public health workforce?	• Thinking of the personnel systems you utilize for hiring, both the county and state systems, are there aspects of these systems that could be improved? • What can be done to strengthen the pipeline from academic institutions into governmental public health? • How are you addressing challenges in terms of having staff that are culturally appropriate or from the local or priority populations? • Given that many staff are not formally trained in public health, what approaches do you use to develop those public health competencies? • What improvements could be made to reduce turnover among employees in the governmental public health workforce? • In terms of emergency preparedness, do you have the tools to rapidly onboard staff? What system-level changes would you like to see to support that effort?

Injury and Violence Prevention

Central Questions	Example Discussion Questions
• How do the foundational public health capabilities at the local level affect our ability to address the risk factors that give rise to injury and violence?	• Where do you find the biggest challenges in addressing violence and injury: in surveillance and monitoring, in identifying risk and protective factors, in developing and evaluating strategies, or in implementing and adopting strategies? • What changes, if any, to the current reporting and surveillance systems for injuries and violence would be most beneficial for your work to address IVP? • How would you describe your capacity to address social determinants of health as it relates to injury and violence prevention? • Could you speak a bit about your partnership with law enforcement to prevent violence and injury? How could that partnership be improved? • What are some high-impact system changes related to the area of injury and violence prevention that would improve your ability to carry out your work?

Maternal and Child Health

Central Questions	Example Discussion Questions
• How do the foundational public health capabilities at the local level affect our ability to address maternal and child health promotion and avoid maternal and infant mortality?	• Thinking of Maryland's system for addressing maternal and child health, which areas are most challenging for you in terms of your population's needs and/or health outcomes and in what ways could they be strengthened? • Are there any specific health programs or initiatives that you feel are underfunded relative to their importance? What challenges arise due to that underfunding? • What practices, policies, or legislation related to maternal and child health promotion would you like to see implemented? • What improvements, if any, would you like to see in the data systems you use for tracking metrics related to maternal and child health in your county? • How would you describe your capacity to address social determinants of health that impact maternal and child health? • What other partnerships don't exist now but would be beneficial for your agency to use its public health capabilities in the area of maternal and child health?

Public Health Emergency Response and Preparedness

Central Questions	Example Discussion Questions
• How do the foundational public health capabilities at the state and local levels affect our readiness to respond to human-caused and natural disasters and emerging pandemics? • What was learned from the COVID-19 experience, and what changes have been/should be made to our preparedness and readiness as a result of that experience?	• Depending on the magnitude of the emergency, federal, state, and local roles may vary. To get us started, let's focus on the state response and think about breaking down emergency response into the following areas: prevention, preparedness, response, and restoration. Which areas do you feel are strongest for Maryland, and which are the weakest? • What is needed to improve the adequacy of current surveillance and data systems in Maryland to identify early warning signs? • What is needed to ensure a sufficient number of individuals are available to be recruited in times of an emergency to assist in the response? • How are you addressing challenges in terms of health equity? How do you ensure that the strategies are culturally appropriate for the priority populations? • Thinking of our discussion today, in what ways could funding be better allocated to create a more responsive system?

Public Health Nursing

Central Questions	Example Discussion Questions
• What are the main challenges facing the nursing workforce as it relates to the foundational public health capabilities in Maryland?	• What are some of the top challenges that come to mind for public health agency nurses as it relates to workforce recruitment, retention, and promotion? What changes could be made at the local or state level to address those challenges? • Thinking of the barriers to career advancement for nurses within your local health department, what system level changes could be implemented to ensure all public health nurses have equitable opportunities for career progression? • Thinking about the role that public health nurses play in public health emergency response, what changes would be most beneficial to support that role? • In what ways do you collaborate with other local, regional, or state entities (e.g., schools, other healthcare providers) to improve public health outcomes? How can those collaborations or partnerships be strengthened? • How would you rate the current data and IT systems in place for managing and analyzing public health nursing data? Thinking of patient records, case management, program evaluation. Rating that from a 1 to a 10, with 10 being the most robust. • Thinking of health equity, do you have the culturally appropriate strategies and tools you need to ensure that you are meeting the needs of priority populations?

ORGANIZATIONAL SURVEY

Purpose

The purpose of the organizational survey was to collect information on the structural and operational aspects of MDH and the LHDs.

Information Collected

Survey questions were primarily derived from suggestions provided by the Commission workgroups. The questions collected primarily quantitative data, although open-ended questions were used where more detail was needed. The assessment team added additional questions to collect information that complemented the responses captured by other assessment activities. Efforts were made to avoid duplicating questions that were asked in the interviews and focus groups. The final survey was reviewed by the Commission and work-group co-chairs.

The LHD survey contained six sections: Organizational Structure, Workforce/Personnel, Funding, Procurement, Data and Information Technology (IT) Infrastructure, and Communication and Public Engagement. The MDH survey collected information on the same topics but organized the questions based on the MDH office that was most appropriate to respond for each topic.

Methodology

LHD responses were collected using an online survey that was available from December 2024 to January 2025. Each LHD completed one survey. MDH responses were collected in early 2025.

Sample

All 24 LHDs completed the organizational survey. Responses were also received from five offices within MDH.

Endnotes

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