STATE OF MARYLAND
OFFICE OF THE LIEUTENANT GOVERNOR

ANTHONY G. BROWN
LIEUTENANT GOVERNOR

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TTY USERS CALL VIA MD RELAY

January 4, 2010

The Honorable Martin J. O'Malley
Governor of Maryland
State House
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House
100 State Circle, Room H-101
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker of the House
State House
100 State Circle, Room H-107
Annapolis, Maryland 21401-1991

Re: Maryland Health Quality and Cost Council

Dear Governor O'Malley, President Miller and Speaker Busch:

Pursuant to Executive Order 01.01.2007.24, we are pleased to submit to you a report detailing the activities of the Maryland Health Quality and Cost Council (MHQCC) in 2009, including the Council's recommendations for improving health care quality and reducing health care costs. To meet this task, the Council established three initial priorities:

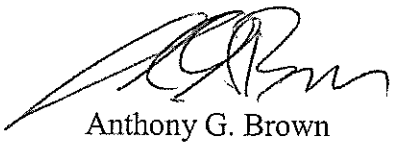
- Develop actionable wellness and prevention strategies to be integrated into a chronic care and disease management plan;
- Coordinate multi-phased quality and patient safety initiatives for acute hospitals settings; and,
- Facilitate statewide implementation of a Patient-centered Medical Home demonstration project.

To facilitate these efforts, the Council created three workgroups, consisting of several Council members as well as individuals from the private sector, academia, and state agencies with expertise related to each workgroup's charge. Through the course of this year, each workgroup narrowed their focus to a handful of key areas and determined initial strategies, supported by measures, timelines, estimated costs and established health benefits.

As this report demonstrates, the strategies outlined by each workgroup will serve as a foundation on which to build future efforts to improve population health, improve quality of care, and contain health care costs within Maryland. This report contains a timeline for the completion of each of the key strategies. In addition, the strategies set forth within this plan were designed to meet the requirements of the Chronic Care Management Plan, required under House Bill 1395 of the 2008 Legislative Session.

We appreciate your continued support of the Council's activities. Should you have questions, please contact Wynee Hawk, Director of Governmental Affairs, Department of Health and Mental Hygiene at 410-767-6481.

Sincerely,



Anthony G. Brown
Chair, MHQCC

John M. Colmers
Vice-Chair, MHQCC

AGB/pcr

Enclosure

cc: Ms. Nicole Stallings
Mr. Ben Stutz
Ms. Wendy Kronmiller
Ms. Mary Mussman
Ms. Frances Phillips
Ms. Maria Prince
Ms. Audrey Regan
Mr. Ben Steffen
Ms. Wynee Hawk
Ms. Sarah Albert

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

December 30, 2009

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401 -1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: HB 1395 (Ch. 693) of the Acts of 2008
Department of Health and Mental Hygiene and Maryland Health Quality and Cost Council - Chronic Care Management Plan

Dear Governor O'Malley, President Miller and Speaker Busch:

The Maryland Health Quality and Cost Council (the Council) was established by Executive Order 01.01.2007.24 to develop recommendations for improving health care quality and reducing health care costs in the State. Subsequently, House Bill 1395 was enacted during the 2008 legislative session which requires the Department of Health and Mental Hygiene (the Department) and the Council to study chronic care management and develop a Chronic Care Management Plan to improve the quality and cost-effectiveness of care for individuals who have or are at risk for chronic disease. The Chronic Care Management Plan required by HB 1395 (2008) is contained in the Council's legislative report (enclosed), and Appendix B of the report outlines the requirements of HB 1395 and how these are addressed in the report.

Two leading recommendations set forth in the Chronic Care Management Plan are the *Healthiest Maryland* strategy and a Patient-centered Medical Home (PCMH) Pilot Program. The Department and Council recommend promotion of *Healthiest Maryland,* a Statewide movement to create a culture of wellness—an environment that makes the healthiest choice an easy choice. There are three components of *Healthiest Maryland* -- Healthiest Maryland Businesses, Healthiest Maryland Communities, and Healthiest Maryland Schools. Within each of the sectors, there is a peer-to-peer recruitment campaign to engage leadership and conduct an organizational assessment, referral to resources and technical assistance, and recognition of successful implementation of policies and environmental change. In addition, corresponding State-level policies and environmental changes will contribute to the culture of wellness throughout Maryland.

The Department and Council also recommend that a Patient-centered Medical Home (PCMH) Pilot Program be implemented. The PCMH is a model of practice in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. Participating practices will test a new care delivery and reimbursement model that provides patient-centered care through evidence-based medicine, expanded access and communication, care coordination and integration, care quality and safety.

Lastly, the Department and Council are recommending strategies that incorporate evidence-based medical strategies, which have been shown to improve healthcare quality, decrease cost, and could be implemented on a large scale cost-effectively. The two leading recommendations are the establishments of a hospital hand hygiene collaborative and a statewide reduction of blood wastage collaborative.

If you have any questions about this report, please contact Ms. Shawn Cain, Assistant Director of Governmental Affairs, at 410-767-6509.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: Anthony G. Brown, Lt. Governor
Wynee Hawk, R.N., J.D.
Ms. Shawn Cain
Frances B. Phillips, R.N., M.H.A.
Mary Mussman, M.D., M.P.H.
Russell Moy, M.D., M.P.H.
Audrey Regan, Ph.D.
Ms. Karen S. Rezabek
Nicole Dempsey Stallings, M.P.P.
Mr. Ben Steffen
Ms. Sarah Albert, MSAR #7309

Maryland Health Quality and Cost Council

Report to the Governor and General Assembly

January 2010

The Honorable Anthony G. Brown, Lieutenant Governor
State of Maryland

John M. Colmers, Secretary
Maryland Department of Health and Mental Hygiene

Maryland Health Quality and Cost Council

MEMBERS AND AFFILIATIONS

Chair: Anthony G. Brown, Lieutenant Governor, State of Maryland
Vice Chair: John M. Colmers, Secretary, Department of Health and Mental Hygiene

Appointees:

Jill A. Berger, M.A.S.
Vice President, Health and Welfare Plans, Marriott International

Debbie Chang, M.P.H.
Senior Vice President and Executive Director,
Nemours Health and Prevention Services

James S. Chesley, Jr., M.D.
Practicing Gastroenterologist

Richard "Chip" Davis, Ph.D.
Vice President for Innovation and Patient Safety, Johns Hopkins Medicine (JHM)
Executive Director, JHM Center for Innovation in Quality Patient Care
Senior Director, JHM East Baltimore Ambulatory Operations

Barbara Epke, M.P.H., M.S.W., M.A.
Vice President, LifeBridge Health System

Thomas A. LaVeist, Ph.D.
William C. and Nancy F. Richardson Professor in Health Policy,
Johns Hopkins Bloomberg School of Public Health
Director, Center for Health Disparities Solutions

Roger Merrill, M.D.
Chief Medical Officer, Perdue Farms Incorporated

Peggy O'Kane, M.H.S.
President, National Committee for Quality Assurance (NCQA)

E. Albert Reece, M.D., Ph.D., M.B.A.
Vice President for Medical Affairs, University of Maryland
Dean, University of Maryland School of Medicine

Leslie Simmons, R.N., B.S.N., M.A.
Chief Operating Officer, Carroll Hospital Center
Senior Vice President of Patient Care Services, Carroll Hospital Center

Reed Tuckson, M.D.
Executive Vice President and Chief of Medical Affairs,
United Health Group

Kathleen White, Ph.D., R.N., C.N.A.A., B.C.
Associate Professor, Johns Hopkins University School of Nursing (JHSON)
Director of the Master of Science in Nursing Program, JHSON
Interim Director, Doctor of Nursing Practice Program, JHSON

STAFF

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Director, Maryland Health Quality and Cost Council
Department of Health and Mental Hygiene

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Physician Advisor, Office of the Deputy Secretary for Health Care Financing
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Department of Health and Mental Hygiene

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Audrey Regan, Ph.D.
Director, Office of Chronic Disease Prevention
Department of Health and Mental Hygiene

Karen S. Rezabek
Health Policy Analyst
Maryland Health Care Commission

Ben Steffen
Director, Center for Information Services and Analysis
Maryland Health Care Commission

Maryland Health Quality & Cost Council
2009 Report

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I. Executive Summary

As sustainable healthcare reform is debated in Washington, Maryland continues to take strides to address health care costs and quality. Maryland is home to a number of medical resources, including world-renowned hospitals, medical and public health teaching institutions and superbly trained professionals. However, by most objective measures, when compared to other states, it is merely average in terms of the quality of its health care system, the health of its population, and the cost of its care. To address these disparate measures, Governor O'Malley issued an executive order establishing the Maryland Health Quality and Cost Council.

In accordance with Executive Order 01.01.2007.24, the Council is required to submit annually an update of activities for the previous year as well as recommendations for improving health care quality and reducing health care costs in the State. To guide this task, the Council established three initial priorities:

- Develop actionable wellness and prevention strategies to be integrated into a chronic care and disease management plan;
- Coordinate multi-phased quality and patient safety initiatives for acute hospitals settings; and,
- Facilitate statewide implementation of a Patient-centered Medical Home (PCMH) demonstration project.

To facilitate these efforts, the Council created three workgroups, consisting of several Council members as well as individuals from the private sector, academia, and state agencies with expertise related to each workgroup's charge. Through the course of this year, each workgroup narrowed their focus to a handful of key areas and determined initial strategies, supported by measures, timelines, estimated costs and established health benefits.

The Wellness and Prevention workgroup was charged with developing actionable wellness and prevention strategies aimed to promote healthy eating and physical activity, assure early detection and linkage to treatment, and engage Marylanders to be proactive in preventing and controlling their chronic conditions. The strategies include the "Healthiest Maryland" campaign, which is a grasstops social marketing campaign designed to engage leaders in the business, community, and school sectors to embrace a culture of wellness. Specifically, leaders from each of these sectors are encouraged to adopt policies that promote and ease healthy eating, physical activity and tobacco use prevention practices. Many strategies fall within the Healthiest Maryland campaign, including creating a Worksite Wellness pilot program for State employees and aligning hospital and payer community benefits. These strategies have been integrated into a chronic care and disease management plan. By March 2010 the Workgroup plans to identify and recruit ambassadors to champion the Healthiest Maryland Businesses initiative that will assist with recruitment. By April 2010, Staff will launch the program with the aim of reaching 75 businesses and 50,000 employees over the course of 18 months. By June 2010, Staff will initiate implementation of policies that promote healthy choices in businesses throughout Maryland and will establish a recognition mechanism with the Office of the Lieutenant Governor for partner businesses that have made successful changes to improve their healthy business environment by April 2011.

The Evidence-based Medicine workgroup was charged with prioritizing the widespread implementation of a limited number of mainly hospital-based practices that have been shown to improve care quality and could be instituted on a large scale relatively quickly. The Workgroup identified two initial strategies. Understanding that an essential element in any healthcare-associated infections prevention program is hand hygiene, the Council recommended Maryland hospitals undertake a coordinated, statewide hand hygiene campaign. The Centers for Disease Control and Prevention and the World Health Organization have shown that adherence to common-sense hand hygiene protocols can dramatically lower hospital infection rates. To maximize hospitals' effectiveness, the Council concluded that it is necessary to introduce some standardization throughout the state and recommended a common methodology that will allow for Statewide comparability. By January 1, 2010 the following benchmarks should be accomplished: initiate the Maryland Hospital Hand Hygiene Collaborative; implement the collection of the Maryland Hand Hygiene Core Data Set at Maryland acute care hospitals using trained observers whose task is unknown to the staff being observed to collect data on adherence to hand hygiene; and, provide feedback to participating hospitals with Maryland performance benchmarks. By July 1, 2010 on-going funding to support the key activities of the prevention collaborative should be identified. The Workgroup also recommended a second initiative to reduce hospital blood wastage. The goal is to ensure there are ample supplies of this precious commodity while curbing expenses associated with wasted blood products. By January 1, 2010, the Workgroup aims to achieve 100% participation among all Maryland blood banks and to set the Collaborative's waste reduction targets. The Workgroup will present findings and a strategy to expand blood wastage reduction efforts Statewide at future Council meeting.

Finally, the Patient-centered Medical Home (PCMH) Workgroup was charged with developing recommendations to strengthen primary care and promote the adoption of the medical home model. The Workgroup identified approaches and funding mechanisms that will encourage the growth and diffusion of PCMHs in the State. Given Maryland's all payer tradition in hospital rate-setting, the Workgroup is working towards the development of an all payer payment system for the PCMH that balances the needs for overall system savings while enhancing primary care practices and the health of the patient population. Next steps for the Workgroup include the introduction a bill by for the 2010 legislative session with commitments of support from all major stakeholders. The Workgroup will work to reach agreement on payment methodology and quality measures by May 1, 2010. By June 1, 2010 the State should execute agreements with Medicaid MCOs, with at least 2 MCOs agreeing to participate in the PCMH demonstration program. Finally, the Workgroup expects to hold statewide symposia beginning June 15, 2010.

The association between strong primary care, improved health of individuals and populations, and reduced health care expenditures is well documented. The strategies outlined by each workgroup will serve as a foundation on which to build future efforts to improve population health, improve quality of care, and contain health care costs within Maryland.

II. Introduction and Background

COUNCIL'S ESTABLISHMENT AND PURPOSE

In October 2007, Governor Martin O'Malley established the Maryland Health Quality and Cost Council (Council).

The Council is tasked with providing the leadership, innovation, and coordination of multiple stakeholders within our health system—payers, institutional providers, physicians, government, patients, and citizens—in an effort to improve the health of Maryland's citizens, maximize the quality of health care services, and contain health care costs.

The Governor's executive order suggests the promotion of wellness, the adoption of advancements in disease prevention and chronic care management, the increased diffusion of health information technology (HIT), and the development of a chronic care plan as important strategies for the Council to consider.

To further define and guide its work, the Council has articulated the vision and mission statements listed below.

> **Vision Statement:** The State of Maryland is a demonstrated national leader in the implementation of innovative, effective cost containment strategies and the attainment of health and high quality health care. The State's efforts are guided by a commitment to ensuring that care is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.
>
> **Mission Statement:** To maximize the health of the citizens of Maryland through strategic planning, coordination of public and private resources, and evaluation that leads to: effective, appropriate, and efficient policies; health promotion and disease prevention initiatives; high quality care delivery; and reductions in disparities in healthcare outcomes.

HB 1395: CHRONIC CARE MANAGEMENT PLAN

During the 2008 legislative session, the Maryland General Assembly elaborated on the development of the Council's chronic care plan, noting that it should include how best to disseminate to health care providers information on evidence-based treatment and prevention practices for chronic conditions. Recognizing that it takes between one and two decades before evidence typically is translated into widespread clinical practice, the legislation suggests that the Council consult with multiple Maryland stakeholders and consider "best-practices" both within Maryland and externally when developing the plan. Moreover, the legislation requires that the Council coordinate with appropriate groups to collect data to evaluate the clinical, social, and economic impact of chronic care and prevention activities in different parts of the State. The strategies set forth within this plan were designed the meet the requirements of the Chronic Care Management Plan.

COUNCIL MEMBERSHIP

In addition to the Lieutenant Governor and the Health and Mental Hygiene Secretary, who serve as the Council's Chair and Vice Chair respectively, the Council consists of twelve other members, each appointed by the Governor for a three-year term. In accordance with the executive order, the Council has at least one representative each drawn from the ranks of the health insurance industry, employers, health care providers, health care consumers, and health care quality experts.

Three of the Council's members represent provider organizations. James Chesley, Jr., M.D. is a practicing gastroenterologist with offices in Prince George's County. Barbara Epke is Vice President at LifeBridge Health System, which consists largely of Sinai Hospital, Northwest Hospital, Levindale Hebrew Geriatric Center and Hospital, and the Jewish Convalescent & Nursing Home, in Baltimore City and Baltimore County. Leslie Simmons, R.N., B.S.N., M.A is the Chief Operating Officer and the Senior Vice President of Patient Care Services at Carroll Hospital Center in Westminster. Ms. Simmons replaced Christine Stefanides, President and CEO of Civista Health, Inc. upon her retirement.

Two of the Council's members are drawn from the ranks of the State's teaching institutions and represent, respectively, medicine and nursing. E. Albert Reece, M.D., Ph.D., M.B.A. is the Dean of the University of Maryland School of Medicine, located in Baltimore City, and also Vice President of Medical Affairs for the University of Maryland system. Kathleen White, Ph.D., R.N. is an Associate Professor and Director of the Masters Program at the Johns Hopkins School of Nursing, also in Baltimore City.

Two Council members represent large employer groups. Jill Berger is Vice President for Health and Welfare Plan Management and Design for Marriott International, headquartered in Montgomery County, and Roger Merrill, M.D. is Chief Medical Officer for Perdue Farms Incorporated, based in Wicomico County on the Eastern Shore.

Reed Tuckson, M.D., and Debbie Chang, M.P.H., represent, respectively, the voices of health insurers and consumers on the Council. Dr. Tuckson serves as Executive Vice President and Chief of Medical Affairs for UnitedHeath Group, based in Minnetonka, Minnesota. Ms. Chang, who is a Maryland resident, is the Senior Vice Present and Executive Director of Nemours Health and Prevention Services in Wilmington, Delaware.

Finally, three of the Council's members are nationally recognized experts on three different facets of health care quality, namely managed care, inpatient care, and health disparities. Peggy O'Kane, who is a Maryland resident, is the President of the National Committee for Quality Assurance (NCQA), a leading developer of quality and performance measures for managed care organizations located in Washington, DC. Richard (Chip) Davis, Ph.D., is the Vice President for Innovation and Patient Safety at Johns Hopkins Medicine in Baltimore City, and Thomas LaVeist, Ph.D. directs the Center for Health Disparities Solutions at The Johns Hopkins Bloomberg School of Public Health, also in Baltimore City.

MARYLAND BASELINE

Maryland is home to a number of medical resources, including world-renowned hospitals, medical and public health teaching institutions and superbly trained professionals. However, by most objective measures, when compared to other states, it is merely average in terms of the quality of its health care system, the health of its population, and the cost of its care.

According to the Commonwealth Fund's State Scorecard on Health System Performance, Maryland ranks only slightly above the middle on an aggregate indicator of health system performance.[1] Although the state performed somewhat better on measures of health care access, equity, and quality than most states, Maryland was below average on key indicators of avoidable hospitalizations and costs of care. On measures of mortality amenable to health care as well as health-related limitations faced by adults, Maryland falls in the lowest quartile.

The Agency for Health Care Quality and Research's (AHRQ) National Healthcare Quality Report in 2008, paints a similarly lackluster picture of the state's health system performance.[2] AHRQ characterized Maryland's performance on chronic and preventative measures as average, while rating its performance on acute care measures as weak. The agency noted greater variability in the State's performance across different settings of care, however: performance on home health care measures was considered strong; performance on ambulatory care, hospital and nursing home measures was considered weak. With respect to disease specific conditions and key populations, AHRQ called the State's performance on cancer and heart disease measures as average compared to that of other states. Performance on diabetes measures and respiratory disease measures was noted as weak, while performance on maternal and child health measures was classified as very weak.

Furthermore, United Health Foundation, which compiles an annual ranking of the health of state populations based on personal behaviors, community and environmental factors, public and health policies, as well as clinical care, also placed Maryland squarely in the middle relative to its peers based on a weighted ranking of these elements.[3] The report noted strengths as ready access to primary care, lower percentage of children in poverty, high immunization coverage and strong per capita public health funding while citing a high incidence of infectious disease and a high violent crime rate as challenges.

With these indicators in mind, the Council set several priorities aimed at improving health care quality and reducing health care costs in the State. The Council's Workgroups have outlined sustainable strategies to address these disparate quality measures.

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[1] Commonwealth Fund Commission on a High Performance Health System. (2009). *Aiming Higher: Results from a State Scorecard on Health System Performance, 2009*. New York: The Commonwealth Fund.
[2] Agency for Healthcare Quality and Research and Quality. (2008). *National Healthcare Quality Report, 2008* (Publication no. 09-0001. Retrieved September 17, 2009, from AHRQ Website: http://www.ahrq.gov/qual/nhqr08/nhqr08.pdf
[3] United Health Foundation. (2008). *America's Health Rankings: A Call to Action for Individuals & Their Communities, 2008 Edition*. Retrieved September 17, 2009 from United Health Foundation Website: Hhttp://www.americashealthrankings.org/2008/pdfs/2008.pdfH.

II. Strategic Plan: Recommendations and Implementation

In accordance with Executive Order 01.01.2007.24, the Council is required to submit annually an update of activities for the previous year as well as recommendations for improving health care quality and reducing health care costs in the State.[4] To guide this task, the Council established three initial priorities:

- Develop actionable wellness and prevention strategies to be integrated into a chronic care and disease management plan;
- Coordinate multi-phased quality and patient safety initiatives for acute hospitals settings; and,
- Facilitate statewide implementation of a Patient-centered Medical Home (PCMH) demonstration project.

To facilitate these efforts, the Council created three workgroups, consisting of several Council members as well as individuals from the private sector, academia, and state agencies with expertise related to each workgroup's charge.

An ongoing effort of the Council will be to understand precisely where the State stands relative to its peers—and why—on key indicators of population health, health care quality, and health system costs. As such, each workgroup began to develop a detailed inventory of existing health improvement initiatives and activities in the state. The workgroups also sought to better understand the health care quality improvement and cost containment initiatives that are being considered and undertaken by other states, as well as international bodies focused on quality of care. The goal of these activities was to note those elements, policies, and practices that have been most successful and thus might serve as a guide or blueprint for the development of a strategic plan.[5] Through the course of this year, each workgroup narrowed their focus to a handful of key areas and determined initial strategies, supported by measures, timelines, estimated costs and established health benefits. As this report will outline, these exercises will serve as a foundation on which to build future efforts to improve population health and the quality of the health care system.

WORKGROUP GOALS AND PROCESSES

The priorities established by the Council aim to improve population health, improve quality of care, and contain health care costs within Maryland. This is, however, a broad and complicated endeavor. To make the task more manageable, the Council decided to narrow the topics on which it would focus, at least in the near term. Accordingly, the Council created three Workgroups: Wellness and Prevention, Evidence-based Medicine and Patient Centered Medical Home. Each Workgroup consists of several Council members as well as individuals from the

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[4] Available: http://www.governor.maryland.gov/executiveorders/01.01.07.24eo.pdf
[5] See Maryland Health Quality and Cost website for a complete review of the public and private sector initiatives that each workgroup considered: http://dhmh.state.md.us/mhqcc

private sector, academia, and government with expertise related to the workgroup's charge. A list of workgroup participation can be found in Appendix A. All Workgroup meetings and conference calls were open to the public and posted on the Council's website.

The Workgroups were responsible for executing the activities listed below for their focus areas and bringing their recommendations to the Council for approval at quarterly meetings. In brief, each Workgroup was tasked with:

- Narrowing its focus to a handful of key areas;
- Determining strategies to be included in the Council's strategic plan;
- Articulating measures, timelines, estimated costs, and estimated health benefits associated with each strategy;
- Addressing proposed legislation and regulatory changes necessary to accomplish proposed strategies; and
- Determining workgroup activities necessary to monitor execution of the strategic plan in 2010 and beyond.

As part of its deliberations when selecting and elaborating on strategies, each Workgroup considered ways to ameliorate disparities and expand the use of health information technology. In addition, each Workgroup thoroughly considered the effect of its proposed strategies on stakeholder groups, such as payers, providers, and patients or consumers, before presenting ideas to the full Council.

WELLNESS AND PREVENTION WORKGROUP

Charge

The Wellness and Prevention workgroup was charged with developing actionable wellness and prevention strategies that fulfill the Maryland Health Quality and Cost Council's charge "to encourage advancements in wellness, prevention, and chronic care management toward the overarching goal of a healthier State." The actionable strategies aim to promote healthy eating and physical activity, assure early detection and linkage to treatment, and engage Marylanders to be proactive in preventing and controlling their chronic conditions.

The strategies include the "Healthiest Maryland" campaign, which is a grasstops social marketing campaign designed to engage leaders in the business, community, and school sectors to embrace a culture of wellness. Specifically, leaders from each of these sectors are encouraged to adopt policies that promote and facilitate healthy eating, physical activity and tobacco use prevention practices. Many strategies fall within the Healthiest Maryland campaign, including creating a Worksite Wellness pilot program for state employees and aligning hospital and payer community benefits. These strategies were prioritized for the State's chronic care and disease management plan, initially focused on childhood obesity, diabetes, and heart disease and stroke.

Methods to Narrow Focus and Identify Strategies

Using the "B.I.G." methodology for priority setting, the Wellness and Prevention Workgroup quickly agreed with a focus on childhood obesity and diabetes as initial priority conditions to address. The BIG priority-setting methodology identifies high-priority conditions based on clinical, social, and economic **burden** (i.e., health conditions that affect the most people (particularly socially disadvantaged people), most severely, and at the greatest cost to Maryland, including the state government, employers, and our health care system). The priority areas identified by other methods such as the Institute of Medicine Priority Areas for National Action and Healthy People 2010 Leading Indicators were considered initially. Next, the BIG prioritization identifies the **improvability** of outcomes for that condition. Improvability implies a large preventable burden of disease; technical feasibility or availability of evidence-based strategies for improvement through promoting wellness and early identification and treatment of disease; large, measurable gaps in prevention and care compared to evidence-based standards; and relatively low current resource allocation. Last, a "**gut check**" is performed to ensure that the identified priorities make sense given the political and social will and existing partnerships to address the priorities.

Strategies for promoting wellness, preventing and controlling chronic disease, and measuring progress were identified from existing guidance from federal Health and Human Services agencies and national public-private partnerships. Examples of these resources which summarize the scientific evidence base include the CDC Guide to Community Preventive Services, US Preventive Services Task Force Guide to Clinical Preventive Services, the CDC cooperative agreement guidance documents for the Nutrition, Physical Activity, and Obesity Prevention Program and the Diabetes Prevention and Control Program, resources from the HRSA Health Disparities Collaborative and the Agency for Healthcare Research and Quality. In addition, resources from national public-private partnerships such as the Healthy Eating and Active Living Convergence Partnership and the National Priorities Partnership were reviewed. Existing Maryland chronic disease strategic plans and plans from other states were also

reviewed.

The potential strategies were presented in a Straw Man Outline (Appendix B) that addresses required components of the Chronic Care Management Plan, specifically:[6]

- strategies for creating healthy environments;
- self-management education;
- dissemination of evidence-based information on prevention and treatment;
- leveraging of public and private initiatives;
- systems for collecting, analyzing, and maintaining statewide data;
- IT solutions as appropriate.

These potential actionable strategies were analyzed by staff based on reach; impact on health, quality, and costs; political feasibility; and ease of administration (time, resources, and cost to state). Four initial priority strategies emerged:

1. "Healthiest Maryland" campaign to engage leaders in their role to create a culture of wellness;
2. Worksite Wellness pilot for state employees;
3. Strategic alignment of community benefits provided by hospitals with complementary efforts and Departmental support;
4. Increasing access to evidence-based self-management programs through reimbursement.

At the June meeting, the full Council requested that staff provide detailed measures, timelines, estimated costs and established health benefits associated with each strategy. After analyzing the potential resources and consulting with partners for implementing proposed strategies, the Healthiest Maryland campaign was identified as a priority for action and redefined to include the State employee worksite wellness initiative. Additionally, the Wellness and Prevention Group identified the Childhood Obesity Committee's potential strategies to champion and integrate in the broader Healthiest Maryland endeavor.

The proposed strategy for alignment of community benefits will be further explored by a new Council on Community Hospitals Connection, an advisory group under the Maryland Hospital Association. The proposed strategy for reimbursement of childhood obesity treatment, diabetes prevention for people with prediabetes, and diabetes self-management education in community settings will be considered in the future due to lack of existing resources.

Wellness and Prevention Strategies

Recommendation 1: Implement Healthiest Maryland throughout the State and within State government.

Healthiest Maryland is a statewide movement to create a culture of wellness – an environment that makes the healthiest choice an easy choice. There are three components of Healthiest Maryland – Healthiest Maryland Businesses, Healthiest Maryland Education, and Healthiest Maryland Communities. Within each of the sectors, there is a peer-to-peer recruitment campaign to engage leadership and conduct an assessment, as well as corresponding policies and environmental changes to create the culture of wellness.

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[6] Required under House Bill 1395 of the 2008 legislative session.

Healthiest Maryland was catalyzed by the Alliance to Make US Healthiest, which was founded by the Association of State and Territorial Health Officials, the Centers for Disease Control and Prevention, and the National Association of County and City Health Officials. The National Business Coalition on Health provides business sector leadership to the Alliance.

The cornerstone of Healthiest Maryland is Healthiest Maryland Businesses, a partnership among businesses throughout the State, which fosters a culture of wellness within work places. Similar to the Maryland Green Registry within the Governor's Smart Green and Growing campaign, Healthiest Maryland Businesses recruits business, conducts an assessment, provides technical assistance, and supports recognition. This particular initiative is prioritized because of the overwhelming evidence supporting worksite wellness, the Health Quality and Cost Council members' experience and success in this arena, and the influence of the business sector in creating the social will to emphasize prevention.

Partnership for Prevention and the US Chamber of Commerce have launched a national *Leading by Example,* CEO-to-CEO initiative that Healthiest Maryland Businesses aims to replicate.[7] According to a review of the literature on the benefits of workplace wellness completed by the Partnership for Prevention:

- The indirect costs (e.g., absenteeism, presenteeism) of poor health can be two to three times the direct medical costs.
- Productivity losses related to personal and family health problems cost U.S. employers $1,685 per employee per year, or $225.8 billion annually.
- A review of 73 published studies of worksite health promotion programs shows an average $3.50-to-$1 savings-to-cost ration in reduced absenteeism and health care cost.
- A meta-review of 42 published studies of worksite health promotion programs shows:
    - Average 28 percent reduction in sick leave absenteeism
    - Average 26 percent reduction in health costs
    - Average 30 percent reduction in workers' compensation and disability management claims costs
    - Average $5.93-to-$1 savings-to-cost ratio

The goal of Healthiest Maryland Businesses to recruit 75 businesses from rural, suburban and urban communities throughout Maryland. Special attention will be made to recruit employers of populations disproportionately affected by chronic diseases and their risk factors, as well as industries whose products and services impact chronic disease risk factors (schools, childcare, healthcare, food service, video game developers, fitness and recreation). Participating Healthiest Maryland Business partners will complete the online Health Management Initiative Assessment, a survey developed and validated by the Partnership for Prevention.

Once recruited, these partners will receive education and technical assistance via online tools and ambassadors, who administer exemplary worksite wellness programs. Existing resources developed and administered by nonprofit health organizations, health insurance providers, hospitals, the Maryland Chamber of Commerce, Greater Baltimore Business Committee, and the Mid-Atlantic Business Group on Health will be disseminated to participating businesses. Workplaces that are exemplary or make substantial improvements will receive public recognition

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[7] Partnership for Prevention is a national membership organization of businesses, nonprofit organizations and government agencies advancing policies and practices to prevent disease and improve the health of all Americans. Details of this initiative are available at http://prevent.org/content/view/30/57/

from the Governor and Lieutenant Governor, media, and events such as “Capital for a Day.”

The Council further recommended the State of Maryland engage in a rigorous, multi-faceted worksite wellness initiative. The State has the potential to serve as a leader in worksite wellness within the public sector and can demonstrate the “Proof of Concept” for an initial investment in wellness that other employers could follow. Four specific areas of a state wellness initiative are:

- Policy and Environmental changes—cafeteria improvement, farmers’ market, vending machines, healthy food procurement policies, smoke-free campus, lactation room, and walking support
- Wellness education—health tips, lunchtime seminar series, on-site weight management program
- Health screening—clinical health screening with on-site counseling, education, and case management (vendor-supported)
- Benefits—enhanced communication of existing benefits and include evidence-based disease management programs.

Measurement:

Measurement will be accomplished through a web-based survey tool to complete the organizational self-assessments. Through these self-assessments, aggregated statewide data will provide a baseline environmental scan of policies and practices that promote healthier living. For Healthiest Maryland Businesses, the self-assessment tools will be converted to an online survey which will be adapted from the Partnership for Prevention’s Leading by Example. Comparable tools will be identified for the school and community sectors.

Healthiest Maryland Businesses aims to reach 75 businesses and impact 50,000 Maryland workers who will be empowered to make healthier choices in a healthier environment.

Timeline:

Phase 1: Engage professional organizations to assist with recruitment, education and recognition of participating companies (Fall 2009-Spring 2010)

Phase 2: Pilot, launch, and analyze companies’ assessment (Fall 2009-Summer 2010)

Phase 3: Develop and secure educational tools and resources for companies (Spring 2010)

Phase 4: Initiate recognition program for participating businesses (Summer 2010)

Phase 5 (dependent on funding availability): Expand to schools and community organizations.

Estimated costs: Medium

Resources are required for staffing and materials to support outreach to business leaders to complete the self-assessment. Grant funding opportunities are currently being explored. Leveraging of current grant funding and partnerships will be used to launch Healthiest Maryland

Businesses. Greater investment is necessary to enhance marketing other than peer-to-peer outreach and to provide resources for leaders to implement changes identified through the self-assessment. One FTE staff is required to coordinate efforts to engage CEOs. The campaign will leverage free publicity from the Lieutenant Governor's and Governor's offices; additional funding will be required for broader outreach. Additional funding will also be required to expand to schools and community organizations.

Established health benefits: High

Creating an environment that supports Marylanders to eat right, be physically active, and stop smoking is not only necessary for prevention of chronic disease, but is essential to management of existing chronic disease. Chronic disease accounts for 75 percent of health spending.

Recommendation 2: Champion the recommendations of promising public and private sector initiatives, including the Maryland Childhood Obesity Report.
During the 2008 Maryland General Assembly, House Bill 1176 established the Committee on Childhood Obesity as part of the State Advisory Council on Heart Disease and Stroke. The Committee's goal was to address the health crisis by reducing the prevalence of childhood obesity and its repercussions in Maryland through the integration of health promotion, program implementation, education, clinical treatment, and surveillance to help children achieve healthy lifestyles. The Committee found that comprehensive, multidisciplinary treatment programs for children who are overweight and obese exist throughout Maryland. However, there are not a sufficient number of programs to meet the need. For children who are overweight or obese, intervention and treatment programs that provide organized physical activity, involve parents/caregivers, and incorporate behavioral management techniques are often most successful in improving weight outcomes. In addition the Committee made several recommendations to improve policies and the environment that make it more conducive for child wellness.

Leading recommendations were:

1. Implement policy and environmental changes that enhance community access to healthy foods, such as statewide expansion of the Baltimore Healthy Stores Program, which has demonstrated success in instituting culturally appropriate store-based interventions to increase the supply of healthy foods and promoting their purchase;
2. Implement policy and environmental changes that enhance community access to physical activity opportunities, such as city planning and zoning policies that include and address results from health impact assessments;
3. Develop a child care wellness policy that includes a review of State child care regulations and implement new requirements to ensure all children are eating healthy food and meeting recommendations for physical activity and reductions in television and computer screen time; and include nutrition and physical activity criteria in the Quality Ratings Improvement System (QRIS) through a wellness policy to be submitted by child care providers who voluntarily participate in the QRIS; and
4. Implement a statewide surveillance system to monitor nutrition, physical activity, and related health behaviors of children.

These recommendations should be considered as Healthiest Maryland is expanded to the school and community setting. Community-based strategies will complement the clinic-based strategies being proposed by the Patient Centered Medical Home Workgroup. In addition, the Council on Community Hospitals Connection, an advisory group under the Maryland Hospital Association, will explore the potential for leveraging community benefits.

Measurement

Measuring the impact of these recommendations can be achieved through existing tools. For example, Healthiest Maryland in the school setting can be measured through a web-based survey tool used to complete the school self-assessments. Through these self-assessments, aggregated statewide data will provide a baseline environmental scan of school-based policies and practices that promote healthier living. Healthiest Maryland Communities will also be measured through a web-based survey.

Healthiest Maryland Children aims to reach 18 of 24 Maryland school districts and impact 400,000 school children and 200,000 children in child care who will have healthier choices in a healthier environment. Healthiest Maryland Communities aims to reach 12 of 24 Maryland jurisdictions through planning and zoning policies that affect all of the Marylanders in those jurisdictions.

Estimated costs: High

Resources are required for program implementation, staffing and materials to support policy and environmental changes among school and community leaders. Applications for the ARRA grant totaled $9.2 million over 24 months.

Established health benefits: High

Health benefits of preventing childhood obesity and instilling healthy habits in childhood have immense payoff in terms of improving children's brain development and readiness to learn and delaying onset of chronic diseases and their complications. In addition, these same strategies will empower Marylanders of all ages to have access to healthy foods and places for physical activity.

Timeline:

Phase 1: Apply for additional resources through American Recovery and Reinvestment Act Communities Putting Prevention to Work funding for competitive special policy and environmental change initiatives (Winter 2009)

Phase 2: Based upon funding awards, prioritize and implement policy and environmental change initiatives for nutrition and physical activity funded by American Recovery and Reinvestment Act Communities Putting Prevention to Work (Winter 2009 – Winter 2011)

EVIDENCE-BASED MEDICINE WORKGROUP

Charge

The Evidence-based Medicine Workgroup is charged with prioritizing the widespread implementation of a limited number of mainly hospital-based practices that have been shown to improve healthcare quality, decrease cost and could be instituted on a large scale relatively quickly. The Council has termed such practices "low-hanging fruit" because the practices to be considered by the group were to be those that are evidence based, with little or no debate about their effectiveness, and that could be implemented in relatively short time periods.

Methods to Narrow Focus and Identify Strategies

During the first call of the group, the Workgroup considered general principles to guide their work. First, Maryland statistics should inform areas for quality improvement or cost reduction projects, where they are available, and baseline data should be collected as part of any project. The group generally focused on relatively inexpensive, quick turn-around projects, but always with a sound evidence base. Because legislation or regulation requires a long lag time, the group favored voluntary participation by hospitals. The group preferred statewide implementation of projects over pilots, and felt strongly that all projects be standardized in terms of metrics to allow consistent and reliable reporting to the Council to demonstrate progress.

The first quarter of activity for the workgroup involved casting a wide net for possible projects that would meet the criteria the group had established. After the initial conference calls the group identified seven possible projects: Hand Hygiene Campaign, Healthcare-Associated Infections (HAIs), Door-to-Balloon Time, Stroke Network (Telemedicine), HIPAA Standard Transaction Sets, Blood Wastage Reduction, and Red Bag Trash Reduction. See Appendix C for a full description of these initiatives. Over the first quarter, many fact-finding calls related to specific initiatives ensued. This included multiple meetings seeking feedback from experts and stakeholders in each of the areas of interest to better understand whether there was a demonstrated need, a political will and adequate time and resources to implement. Several of the original seven proposed projects were dropped in preparation for the March 20 Council meeting. HIPAA standard transaction sets was dropped because of technological complexity to the extent the group found that it was not "low-hanging." Red bag trash was regarded as overly focused on cost reduction rather than quality. Both of these initiatives remain on the Workgroup's inventory of possible projects for the future, however. Prior to the March meeting, the Workgroup had begun to discuss the ways in which the Hand Hygiene Campaign and Healthcare-Associated Infections projects were intrinsically linked and decided that they should be addressed as a unit.[8] At the March 20 meeting, the Council approved continued work on Hand Hygiene Campaign, Healthcare – Associated Infections, Door to Balloon, and Blood Wastage, but felt the evidence was less clear on the Stroke Network (Telemedicine) Project. The Stroke Network was tabled, for future review when perhaps additional evidence is presented.

Upon Council approval of the Workgroup's general direction, the group delved deeper into each of the remaining initiatives by assembling evidence, engaging necessary stakeholders, estimating resources required, and searching for existing baseline data. The Workgroup became more convinced that Door to Balloon Time, an attempt to reduce time between arrival

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[8] The presentation of the Workgroup's recommendations presented at the March 20 Council meeting please see http://dhmh.maryland.gov/mhqcc/materials/council/032009/EBM_Recommendations_Presentation.pdf

at the ED and patient entry in to the catheterization lab for patients with S-T elevation myocardial infarctions by use of 12-lead ECG transmitters in the field, did not meet the workgroup's criteria for quick turn-around and low resource use. The project was discussed at length with Maryland Health Care Commission (MHCC) and the Maryland Institute for Emergency Medical Services System. In addition, research suggested the evidence was equivocal. At the June 10th meeting, Dr. Davis presented the March 20 initiatives minus the Stroke project, and expressed the workgroup's ambivalence about addressing Door to Balloon Time as an initial strategy.[9] At that meeting, Dr. Davis presented a timeline and possible scorecard for each of the initiatives as well.

Thus, the Council ultimately approved two projects: a Hand Hygiene Campaign coupled with Healthcare- Associated Infections, and Blood Wastage Reduction, and signed off on the proposed timeline and scorecard concept that would enable transparent aggregate reporting across the State. The general method for implementing these initiatives across the board was the use of (short-term) collaboratives, including the hospitals, MPSC, MHCC, Maryland Hospital Association, and other stakeholder groups such as the Red Cross. The momentum surrounding preparation for H1N1 was raised as the burning platform to initiate the Hand Hygiene Campaign, as well. The workgroup then began to design the specific initiatives, with the expectation that both projects would be implemented in the Fall of 2009.

Evidence-based Medicine Strategies

Recommendation 1: Implement Hand Hygiene Campaign aimed to reduce Healthcare-Associated Infections

Healthcare-associated infections (HAIs) are a major cause of morbidity and mortality. They directly impact a patients' length of stay which directly impacts a hospital's capacity as well as costs. The HAI problem is complicated by the rising prevalence of colonization and infection with multidrug resistant organisms (MDROs). Up to 70 percent of all reported HAIs to the Centers for Disease Control and Prevention (CDC) are caused by organisms that are resistant to at least one antibiotic. Medical experts, the CDC, and the World Health Organization all agree that hand hygiene remains our cornerstone intervention for preventing HAIs and transmission of pathogenic organisms in the healthcare setting. The most common mode of transmission of pathogens in this setting is believed to be via healthcare workers' hands. Indeed, improved hand hygiene has been associated with reductions in HAIs and MDRO transmissions. Literature reports notable decreases in nosocomial infection rates and reduced MRSA acquisition and infection rates with improved hand hygiene[10] Guidelines for hand hygiene have been published by the CDC, and WHO and targets for hand hygiene compliance have been set by The Joint Commission for hospital accreditation. Unfortunately, adherence to hand hygiene guidelines continues to be poor among healthcare workers as a result of multiple reported barriers including lack of time, work stressors, skepticism about impact of hand hygiene on HAI rates, lack of knowledge, lack of role models, effects of hand cleaning agents on skin, lack of leadership emphasis on problem, etc.

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[10] The June 10 presentation to the Council is may be accessed at: http://dhmh.maryland.gov/mhqcc/materials/council/061009/MHQCC_June10_Med_Home_Presentation.

[10] See Doebbeling et al. 1992. "Comparative efficacy of alternative handwashing agents in reducing nosocomial infections in intensive care units." New England Journal of Medicine. Vol. 327, 88-93 and Pittet, et al. 2000. "Effectiveness of a hospital-wide programme to improve compliance with hand hygiene." *The Lancet*, Vol. 356 (9238), 1307-1312

The Council endorsed a statewide hand hygiene campaign that aims to achieve immense life and cost-saving potential represented by a significant reduction in the number of healthcare-associated infections. While the Council acknowledged the significant work already underway in the State's acute care facilities there was significant focus on the lack of uniform measurement by which to measure improvement across facilities. With this in mind, the Workgroup sought the input of the MHCC HAI Advisory Committee, a two year old group that represented the expert panel for this topic area in our state. Committee members include infection control representatives from a sample of Maryland Hospitals. See Appendix D for an overview of the activities of the MHCC and the HAI Advisory Committee related to healthcare-associated infections. Established as the Expert Panel for this initiative, the group, chaired by Pam Barclay at MHCC, reviewed HH tools generally available, including the JHM WIPES campaign, the National Healthcare Safety Net (NHSN) tool, and WHO and Joint Commission materials. In addition, they conducted a survey of current Maryland hospital efforts in the area of hand hygiene. The survey, its results, and descriptions of the various tools are included in the Report and Recommendations on Implementation of a Statewide Hospital Hand Hygiene Campaign.[11] At the request of Secretary Colmers, the Report contains guiding principles, methodology, and data collection recommendations. It was produced by a subcommittee of the HAI committee working diligently over the month of August.

The group made the following recommendations:

- Public Education

  Recommendation 1. In conjunction with the statewide hospital Hand Hygiene Campaign, the Maryland Council on Health Quality and Cost, and the MHCC's Healthcare-Associated Infections Advisory Committee should develop a public awareness campaign to emphasize the importance of hand hygiene in preventing HAIs, including influenza.

- Measurement and Hand Hygiene Compliance

  Recommendation 2. The Healthcare-Associated Infections Advisory Committee recommends that hospital hand hygiene programs be supervised by Infection Preventionists.

  Recommendation 3. The Healthcare-Associated Infections Advisory Committee recommends that hospital programs measuring adherence to hand hygiene protocols be required to use trained non-Infection Preventionist staff to conduct observations.

  Recommendation 4. The Healthcare-Associated Infections Advisory Committee recommends that hospital programs measuring adherence to hand hygiene protocols be required to use trained observers to perform data collection. A formal, statewide program should be developed to train observers to ensure the collection of consistent and reliable data on hand hygiene adherence.

  Recommendation 5. The Healthcare-Associated Infections Advisory Committee recommends that hospital programs be required initially, at a minimum, to collect data on adherence to hand hygiene protocols: after touching a patient or touching a patient's surroundings; by major discipline of health care worker, including nurses, physicians, environmental services, food services, and ancillary support staff who enter patient

[11] Available: http://mhcc.maryland.gov/healthcare_associated_infections/hai/handhygiene.pdf

environments; and, for inpatient and intensive care units and the emergency department. There should be a minimum of 30 observations per month for each unit.

- Data Collection and Implementation
  Recommendation 6. The Healthcare-Associated Infections Advisory Committee and its Hand Hygiene and Prevention Subcommittee should work with the Maryland Patient Safety Center (MPSC) to implement a statewide Hand Hygiene Campaign. The MPSC: should identify a limited number (e.g., 2-3) of existing tools that could be used to support a statewide hand hygiene campaign; develop a common approach to calculate adherence rates that provides comparable data across hospitals; define the minimum number of inpatient units to be reported by each hospital; and, develop a training program to support the collection of valid hand hygiene compliance data.

These recommendations were used to develop the Maryland Hospital Hand Hygiene Collaborative. A coordinated, statewide effort is the most effective and successful approach to having a positive impact on infection prevention practices. It is significantly more efficient than the current patchwork of individual, well-intended, but divergent facility efforts. The goal of 100% participation by Maryland's Acute Care General Hospitals ensures coordinated, comprehensive and sustainable improvement.

Maryland Hospital Hand Hygiene Collaborative

A statewide kickoff meeting to begin implementation of the Maryland Hospital Hand Hygiene Collaborative was held in November 2009. The Collaborative is being led by the Maryland Patient Safety Center. The Infection Prevention Subcommittee of the HAI Advisory Committee is serving as the Expert Panel to the Collaborative. The goal of the collaborative is to collect a standard data set for measuring hand hygiene compliance, provide timely feedback to participating hospitals, and monitor improvements in hand hygiene over time. Data reflecting HAI outcome measures will be tracked to assess the impact of hand hygiene compliance in preventing HAI. To ensure the reliability of the data, the measurement methodology will employ observers whose task is unknown to the staff being observed who are trained using a standard set of materials. In this manner, inter-rater agreement will be established to facilitate the collection of data that can be compared across institutions. As of December 2009, 44 of the 47 acute care hospitals in Maryland are participating in the Maryland Hospital Hand Hygiene Collaborative.

Participating organizations benefit by having access to:

- Collaborative Learning Sessions and conference calls;
- Hand Hygiene tools and resources, including campaign-style materials and templates;
- An online data management and feedback system with the ability to:
  - Create a customized data collection tool for each hospital or hospital system;
  - Enter data directly into a data base using a hand-held device; and
  - Provide organizational, provider and unit level specific feedback reports
- A web-based training program to improve standardization of the unknown hand hygiene observers;
- An organizational audit tool to evaluate current hand hygiene efforts; and
- A network of experts and colleagues.

The Maryland Patient Safety Center, in collaboration with the Delmarva Foundation and the

Maryland Hospital Association has developed a website that offers complimentary resources to participants as well as an email distribution list of all participants to ensure ongoing communication.[12] Hospitals will begin to enter compliance data into the data base in January. Aggregate data will be presented to the Council on a quarterly basis for the purpose of documenting the progress of the Collaborative and the extent of improvement. The Collaborative aims to achieve 90 percent hand hygiene compliance for all participants by the end of the 12 month period. The Council, the MHCC and the Maryland Patient Safety Center will work to identify an ongoing source of funding to support the continuation of the Collaborative.

Timeline:

Planning, Development – Summer 2009

Kickoff off Campaign – November, 2009

Training for Tools – November/December
- Standardized Observer Training
- Data Submission and Web Reporting

Begin Data Submission – January 2010 (monthly submission)

Continued Engagement with Hospitals through January 2011
- Quarterly "Learning Sessions"
- Monthly Sharing Calls
- Participant Conference – Spring 2010

Costs:

To partially support this effort, the Maryland Department of Health and Mental Hygiene, Infectious Disease and Environmental Health Administration, in partnership with the MHCC, applied for and were awarded funding from the Centers for Disease Control and Prevention in support of the surveillance and prevention of healthcare-associated infections. The $1.2 million total award will fund improvements to epidemiology and data analysis staffing as well as two collaboratives – one on hand hygiene and one focused on multi-drug resistant Acinetobacter. The hand hygiene collaborative will focus on training hospital hand hygiene adherence monitors and set up a web-based system to collect data from hospitals. See Appendix E for a summary of the grant application. In addition, the hand hygiene collaborative relies on a significant amount of in-kind support from the Maryland Patient Safety Center, the Delmarva Foundation, the Maryland Hospital Association and Johns Hopkins Medicine's Center for Innovation in Quality Patient Care.

Recommendation 2: Implement a Blood Wastage Reduction Initiative

The Workgroup's second initiative aimed to reduce blood wastage after it was learned that the variation in the way blood is used, stored, and saved can be reduced – and this can be done

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[12] See for example, the Collaborative Toolkit, FAQs and webinar recordings at: http://www.marylandpatientsafety.org/html/collaboratives/hand_hygiene/index.asp

inexpensively and relatively easily. The cost savings accrue directly to hospitals/care providers in proportion to the effectiveness with which they roll out this type of program. For example, a Lean Sigma initiative designed by The Center for Innovation in Quality Patient Care at Johns Hopkins resulted in sustained reductions in blood waste. In two years, over 4,700 units of blood were saved, corresponding to a $900,000 savings to the hospital. It was agreed that blood is a precious commodity and that the variability of the supply directly impacts the ability to provide blood when needed. The Council felt that addressing blood wastage as a public health issue would also increase the efficiency of hospitals, thereby improving both quality and cost.

After the Council approved the Blood Wastage Reduction project, LifeBridge Health's Blood Bank Manager, Donna Marquess, I-Fong Sun from Johns Hopkins Medicine's Center for Innovation in Quality Patient Care and Page Gambill of the American Red Cross volunteered to coordinate the project. The group established the Blood Wastage Workgroup and held their first meeting at the American Red Cross Headquarters in July 2009.[13] This initial meeting was followed by a survey of a representative sample of Maryland Hospital blood banks about their practices to keep waste at a minimum, their waste monitoring practices, and where their waste occurred.

The survey results pointed to two blood components with suboptimal wastage rates and high "average selling price," platelets and plasma. In addition, the survey started a collection of best practice that would later serve as a repository for blood bankers to access. Survey responses raised concern about the variation in transfusion criteria used across the state, and suggested dissemination of evidence-based guidelines on this topic might be a secondary project to follow the implementation of the wastage reduction program.

Over the course of frequent phone calls two project charters were developed: one to reduce discarded plasma units and one to reduce discarded platelets. These charters each required standardized definitions for "discarded" products and "blood unit" measurements, with specified numerators and denominators for data collection.[14] In August, the workgroup then sought feedback from a larger group of hospitals to ensure both future buy-in to the principles of the Collaborative as well as applicability of content across a broader scale.

Maryland Statewide Reduction of Blood Wastage Collaborative

The kick-off conference call for the Maryland Statewide Reduction of Blood Wastage Collaborative was held on September 22, 2009.[15] Twenty-four hospitals and two blood suppliers (i.e., American Red Cross and Delmarva) participated in the call. During the kickoff call, the co-chairs reviewed with the participants the background of the initiative, survey results, project charters, selected measures, data collection tools (both manual and electronic), best practices, as well as the Pledge of Participation.

The Pledge of Participation follows the principles of the IHI Collaborative model and requires all participants to sign along with the institution's executive champion. As of December 8, 2009, 44 out of 45 hospital blood banks were participating in the Collaborative, for a participation rate of 98 percent (See Appendix F). The Blood Wastage Workgroup assisted in the development of

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[13] See Appendix A for a list of all Workgroup members.
[14] Details of this Collaborative, including, charters, data collection template, pledge of participation and best practices are available at: http://dhmh.maryland.gov/mhqcc/evidence.html
[15] The Blood Wastage Reduction Collaborative Kick-off presentation is available at: http://dhmh.maryland.gov/mhqcc/pdf/2009/oct09/BWWG_09_22_09_Final.pdf

a website in which Collaborative participants are be able to submit monthly metrics electronically, to view reports comparing themselves against aggregate results, and to query a database of submitted best practices. Beginning in November 2009, participants were able to submit their monthly blood wastage data on the Maryland Blood Wastage Collaborative Website. Baseline data (Sept. 1, 2008 to Aug. 31, 2009) and the Pledges of Participation were submitted by October 16, 2009. Data is submitted by Collaborative participants monthly and the Blood Wastage Workgroup will provide quarterly reports on the state aggregate blood wastage data to Council. The Blood Wastage Workgroup will also coordinate quarterly follow-up calls with all Collaborative participants to discuss best practices and data submitted.

The Workgroup is currently exploring an enhancement to the Blood Wastage website that would allow for blood banks to post soon-to-be expiring inventory to allow nearby facilities to know what is available during emergent situations. The Workgroup is in the process of investigating potential regulatory hurdles as well as areas of liability.

Timeline:

Program Development – August 2009

Kickoff of Collaborative – September 2009

Baseline Data – October 2009

Completion of Website – November 2009

Monthly Data Submission – Sept 1, 2009 – August 31, 2010

Participant Conference – Spring 2010

Costs:

This voluntary Collaborative was initiated at no cost to the State and minimal cost to participants; however, the Red Cross, LifeBridge Health and Johns Hopkins Medicine's Center for Innovation and Quality Patient Care have invested a significant amount of time in the coordination of this initiative. This effort has already produced great results. For example, in just two months of collaboration (Sept. – Oct. 2009), the participating hospitals have saved 115 units of platelets for a total savings of $58,355. This effort is a prime example of initiatives that are low cost and yield high impact results.

PATIENT CENTERED MEDICAL HOME WORKGROUP

Background

The association between strong primary care, improved health of individuals and populations, and reduced health care expenditures is well documented. Population health measures, including all-cause mortality, and mortality from specific diseases such as heart disease, cancer, and stroke, are better in areas with more primary care physicians, even after controlling for a variety of other influences on population health.[16] Studies conducted in the US and elsewhere have shown that routine access to primary care providers is one major factor in the improved health of the population.[17]

A significant number of people in Maryland do not have access to high quality primary care.[18] For those who do, the health care system does not encourage primary care providers to develop relationships with them and, when appropriate, their families, to better address the complete array of their health issues. Recent studies indicate that fewer than 30 percent of all US medical students are choosing primary care specialties.[19] Availability of primary care is particularly limited for low-income individuals and members of racial and ethnic minorities – people who are disproportionately likely to be in poor health and least likely to have a dependable source of health care services.[20] Substantial evidence indicates that access to a medical home – defined as timely, well-organized care with enhanced access to providers – can reduce or eliminate racial and ethnic disparities in health outcomes.[21]

Even as the need for primary care providers increases, medical school graduates and interns have shown an increasing reluctance to enter the field of primary care. Three factors account for declining interest in primary care medicine: first, growing undergraduate medical education emphasizes surgical and medical specialization; second, significant income inequities across medical and surgical specialties discourage selection of primary care, especially given that most medical school graduates have accumulated significant debt; and third, medical school undergraduates' perceptions of practice environments and employment opportunities in primary care are negatively affected by the current primary care practice environment and the limited ability to maintain manageable work hours. The time demands of primary care were recently estimated in a study conducted by Dr. James Michner and his colleagues at Duke University.[22] Taken together, providing care for preventive services, chronic, and acute conditions for an average patient panel would require 21.7 hours a day. The time required to deliver all recommended primary care is almost three times that which is available per physician. To meet

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[16] Starfield, B., Shi, L., and Macinko, J. 2005. Contribution of primary care to health systems and health. *Milbank Quarterly* 83, no. 3: *457–502.*

[17] Kravet, S., Shore, A., Miller, R., *et al.,* 2008. Health care utilization and the proportion of primary care physicians, *American Journal of Medicine,* 121, no. 2: 142–148

[18] Maryland Hospital Association and Maryland Medical Society, "Maryland Physician Workforce Study", January 2008, available at: http://mlis.state.md.us/2009rs/misc/ReviewPhysicianShortages.pdf

[19] Roehrig, Charles and Turner, Ani, "Update of Modeling and Analysis for Determining Supply of and Demand for Residency Positions by Specialty," Council on Graduate Medical Education, April 22, 2009

[20] Shi L., Macinko J., Starfield B., *et al.,* The relationship between primary care, income inequality, and mortality in US States, 1980–1995. *J Am Board Fam Practice,* Sept.–Oct. 2003; 16(5):412–422.

[21] Task Force on Health Care Access and Reimbursement, *Final Report and Recommendations*, December 2008, available at: mhcc.maryland.gov/legislative/hcar_taskforce_finalrpt.pdf - 2009-01-20

[22] Yarnall, KSH, Ostbye T, Krause KM, *et al.,* Family physicians as team leaders: "Time" to share the care." *Prev Chronic Dis* 2009;6(2). Available at: http://www.cdc.gov/pcd/issues/2009/apr/08_0023.htm

guidelines for chronic disease management and prevention, physicians would need to work 22-hour days and reorganize their practices so that they spend almost 50 percent of their time in chronic disease management as well as a third of their time in preventive care. The time requirements for delivering quality primary care contribute to shortfalls in care delivery and help explain why attracting new physicians into a primary care practice is challenging. In summary, incentives in medical education, income inequalities, and shifting views on the appropriate balance among work, family responsibilities, and leisure have all contributed to declining interest in primary care.

Increasingly, private and public payers are interested in better supporting the provision of effective primary care. One approach for providing patient care that has generated significant interest is the Patient Centered Medical Home (PCMH). In the PCMH model, teams attend to the needs of patients and provide whole person, patient centered care. The four major primary care physician groups – American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association – as well as national employers, health plans, and others – agree that the PCMH model is a way to evaluate the role of the primary care provider in our health system, while providing high quality lower cost patient care.[23]

Converting a primary care practice to a medical home is a major transformation and includes a practice management redesign, changes to the staff, behavioral changes for both clinicians and patients, expanded communication, and electronic medical record system implementation, which should yield lower costs, improved clinical care processes, increased patient access, enhanced patient experience of care, and improved satisfaction for the clinical staff.

Experience from other states shows that championing the Patient Centered Medical Home specifically, and primary care generally, is an important factor in the successful launch of the program. A pilot is needed to build the necessary momentum to fully test the medical home model. Recognizing that a champion was needed to chart the planning of the PCMH pilot, Governor O'Malley's Task Force on Health Care Access and Reimbursement recommended:

> "The newly established Quality and Cost Council should be charged with creating a uniform statewide approach to assist physician practices in establishing medical homes by:
>
> a. Promoting the formation of medical homes based on the ACP's principles for Medical Homes;[24]
> b. Creating multi-stakeholder coalitions composed of payers, providers, and purchasers that will develop common reimbursement and performance incentives for medical homes;
> c. Identifying equitable sources of start-up funding so that initial costs can be shared among providers, payers, and purchasers commensurate with the longer-term benefits;
> d. Mobilizing the multi-stakeholder coalitions to compete for medical home demonstrations offered by CMS. A significant number of people in the United States do not have access to high quality, point-of-entry, primary care. For those with access to primary care, the health care system does not encourage primary care providers to develop relationships

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[23] See, for example, the Patient-Centered Primary Care Collaborative at: http://pcpcc.net//. Over 100 provider, payer, purchaser, and consumer organizations have endorsed the patient centered medical home as a means of delivering more cost effective primary care.

[24] American College of Physicians, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care," Washington, DC, 2006

with them and, when appropriate, their families, to better address the complete array of their health issues.

Availability of primary care is particularly limited for low-income individuals and members of racial and ethnic minorities – people who are disproportionately likely to be in poor health and least likely to have a dependable source of health care. Substantial evidence indicates that access to a medical home – defined as timely, well-organized care with enhanced access to providers – can reduce or eliminate racial and ethnic disparities in health outcomes.[25]

Provider prospective: Why a multi-payer model?

The conversion of a primary care practice to a medical home requires transforming a practice's clinical, technical, and business processes and operations. The evolution of a primary care practice to a medical home involves the development of new practice processes and a significant injection of capital.

Some groups have pegged the initial conversion costs at $100,000 per full-time equivalent (FTE) physician, and the American Academy of Family Practice (AAFP) estimates one-time expenses at up to $75,000 per physician.[26, 27] Implementation of an electronic health record system, a key requirement of a medical home, may take a year or more to become fully operational. Work flow changes must also occur during that time, resulting in a decrease in office productivity. New functional roles, such as a care coordinator who will support patients needing ongoing care, must be defined and either new staff hired, or existing staff trained to serve that function.[28] The costs of these changes are difficult for a practice to justify if only one sponsor supports the adoption of the medical home model. Given the cost of adoption to practices, they are more likely to participate if all the major payers participate in the pilot.

In most multi-payer pilots, payers select the same core group of practice sites using a common set of practice qualifications. Payers ask the pilot sites to implement the same set of new clinical services drawn from the Patient Centered Medical Home (PCMH) Principles. All payers evaluate practices using the same measures drawn from national measurement sets. The method and intent of incentive payments is consistent across all payers. Plans and providers agree to a common member attribution methodology and standardized quality metrics.

Payer prospective: Why a multi-payer model?

Several of the major insurance carriers in the state have been supportive of the PCMH model. CareFirst launched an 11-practice pilot in the spring of 2009. If multiple sponsors are available, the initial costs can be more widely distributed among carriers. Close to home, Pennsylvania is testing a multi-payer collaboration focusing on applying a medical home model to chronic care. Aetna, a carrier that sells in the Maryland market, is an active participate in the Pennsylvania pilot.[29] UnitedHealthcare (UCH) has worked with practices in Arizona and other states. A single payer sponsor will find it difficult to launch a demonstration that includes more than a handful of practices, or to capture significant savings that result. Most of the cost savings that a

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[25] Task Force on Health Care Access and Reimbursement, *ibid.*

[26] Deloitte Consulting, Center for Health Care Solutions. 2008. *The Medical Home, Disruptive Innovations.* Washington, D.C., available at http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf.

[27] American Academy of Family Practice. 2004. *The Future of Family Medicine,* available at http://www.annfamed.org/cgi/reprint/2/suppl_3/s1.

[28] Deloitte Consulting, Center for Health Care Solutions, *ibid.*

[29] See Pennsylvania's Chronic Care Management, Reimbursement and Cost Reduction Commission, Transforming Primary Care Practice: The Southeast Pennsylvania Rollout, Donald Liss, M.D. and Richard Snyder, M.D., available at: http://dhmh.state.md.us/mhqcc/pcmh.html

sponsor can achieve will accrue through the enhanced care coordination and management functions of the medical home. As the functions come online after the new technical and clinical infrastructure is in place, savings will be generated only after a medical home is fully operational.

Benefits of State Involvement

Multi-stakeholder PCMH pilots require leadership from an impartial convening organization. Payers face a host of uncertainties about participation in multi-payer PCMH programs. Benefits of collaboration are unclear, the risk of losing market share can be significant, most carriers are unaccustomed to collaborating with competitors, and private payers often believe they have little in common with the Medicaid programs that are also likely to be participating payers. The Council has overcome some of these issues by serving as the convener of the pilot. However, Workgroup staff have identified potential legal issues that may limit the ability of providers and payers to participate in the pilot, given current restrictions in Maryland. Council and Workgroup staff have been advised by Maryland Assistant Attorneys General that the Executive Order establishing the Council does not specifically provide anti-trust protections. Maryland law severely restricts the use of capitation and bonuses based on quality. In addition, Maryland law limits the sharing of data as envisioned in the proposed PCMH pilot and statutory authority is necessary to execute a binding agreement with payers regarding payment to providers under contract. Further, changes in Maryland law are necessary for Maryland State employee benefits plan beneficiaries to participate in the PCMH pilot.

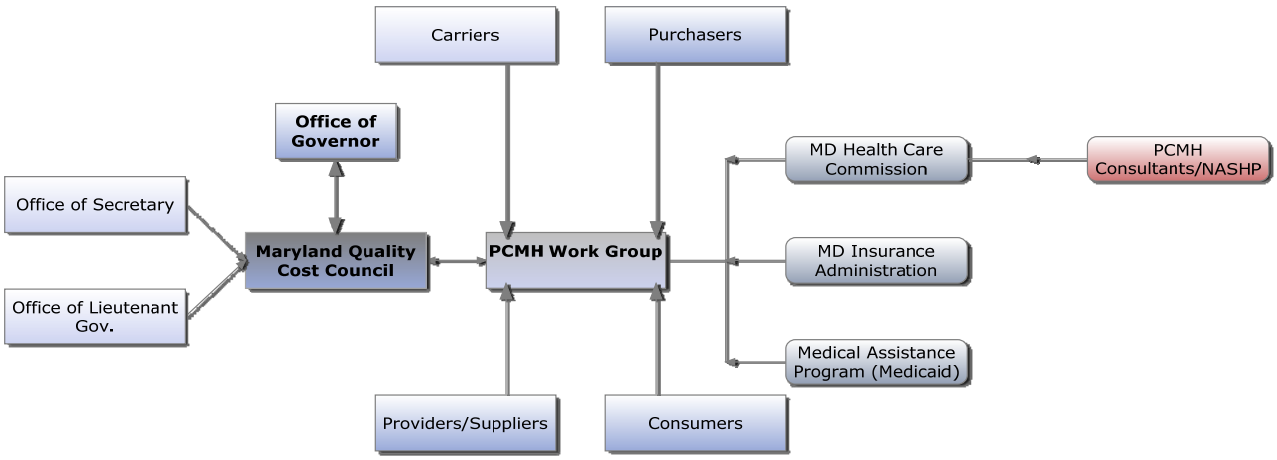
Assistant Attorneys General from the Maryland Insurance Administration (MIA) and the Department of Health and Mental Hygiene (DHMH) have provided interpretation of current law and recommended statutory changes in the Maryland Insurance Article and the Health General Article. Staff will complete a draft and identify legislative sponsor(s) in December 2009. The deadline for approval to submit an administration and a departmental bill has passed. Private sponsors will be needed, although it is expected that DHMH, MHCC, and MIA will strongly support the bill. Council and Workgroup staff anticipate that legislative staff from the respective organizations would be available to assist in generating support from MedChi (Maryland AMA), the Maryland Hospital Association, and the several specialty societies that have endorsed the PCMH principles at the national level.

Charge

The Patient Centered Medical Home Workgroup is charged with developing recommendations to strengthen primary care and promote the adoption of the medical home model. The Workgroup was to identify approaches and funding mechanisms that will encourage the growth and diffusion of PCMHs in the State. Given Maryland's all payer tradition in hospital rate-setting, the Workgroup hopes to develop an all payer payment system for the PCMH that balances the needs for overall system savings while enhancing primary care practices and the health of the patient population.

The Workgroup brings together the key organizations within State Government that will be responsible for the pilot and the important stakeholders that will be needed to launch the initiative. The organization chart below depicts the organizational relationship between the Council, the Workgroup, State agencies and stakeholders.

The Organizational Relationship of the PCMH Work Group to State Agencies and Key Stakeholders



Methods to Narrow the Focus and Identify Strategies

The Workgroup has used a rapid decision-making approach consisting of five primary components to address the key issues under the Council's charge within a limited time frame.

Table 1. The Workgroup's Approach for Reaching Recommendations

Component	**Purpose**
Convene meetings of stakeholders familiar with primary care issues	Build a broad consensus and ensure that decisions and recommendations are supported by the broader health care community.
Search the PCMH literature and experience gained to identify best practices and approaches.	Identify the work of states; provider, health plan, and professional organizations; regulatory agencies; public and private foundations; and researchers who are actively working to "build" PCMHs.
Develop recommendations and give stakeholders an opportunity to provide feedback.	Provides for a pre-implementation reality test. Gives stakeholders an opportunity to comment on the appropriateness and workability of concepts for Maryland.
Periodically present Workgroup recommendations to the Council.	Actively engage the Council in recommendations and provide opportunity for early feedback, refinement, and alignment of Workgroup decisions with broader Council goals.
Receive feedback from the Council and finalize Workgroup recommendations	Provide linkage back to the Workgroup for prompt refinement and final resolution.

At its first meeting, the Workgroup formulated an action plan and the staff identified nine areas within that plan on which agreement is needed. The nine areas, which are shown in Table 2, allowed the Workgroup to identify important issues that needed to be addressed before further planning could continue. Some areas, such as defining the PCMH and determining pilot participants, were self-evident. Other areas, such as delineating provider recruitment strategies,

were more difficult to visualize. The Workgroup formed three subgroups to address some of the nine areas in a more focused manner and to consider the broadest range of options, while building areas of consensus that had been identified. The subgroups met many times in 2009 to discuss the issues under their domains.

Table 2. PCMH Workgroup – Action Plan
Subgroup Assignments

Action Areas	***Subgroups***		
	Medical Home Foundations	**Practice Transformation**	**Purchasers and Consumer Education**
Define the patient centered medical home.	***X***		
Define practice and payer participants.		***X***	
Designate the payment and recognition methods.	***X***	***X***	
Delineate measurement methods for quality, efficiency, and satisfaction.	***X***		
Identify legal issues that need resolution (Medicaid, anti-trust, safe-harbor).	***X***		
Develop a provider recruitment and training strategy.		***X***	
Determine funding sources.	***X***	***X***	
Identify sources of technical and infrastructure support (government, NGO, private).		***X***	
Create standards for a patient education program.			***X***

Note: The Purchaser and Consumer Education Subgroup meet once during the summer of 2009. Further meetings were deferred until after the scope of the pilot was further defined.

The Workgroup was able to cover much of its agenda during 18 meetings from March through December 2009. During each of the meetings, members were actively engaged in the issues under discussion. Several Workgroup members made formal presentations: NCQA described the PCMH recognition process and CareFirst and UnitedHealthcare provided overviews of PCMH demonstrations underway in Maryland and in several northeastern states, respectively. Two provider members of the Workgroup, physicians from Potomac Physicians and Bay Crossing Family Medicine, spoke frankly about the challenges their practices had faced in becoming PCMHs. This information was particularly useful to many of the non-clinical participants. Potomac Physicians is the only practice in Maryland that has achieved Level III PPC-PCMH recognition. Bay Crossing Family Medicine is one of 36 practices in the United States that participated in AAFP's first National PCMH Demonstration.[30] Workgroup was further facilitated by external presentations by staff from the National Academy of State Health Policy on the implementation of PCMHs in other states, by Aetna Health Plan's presentation on the role of private payers in the Pennsylvania Chronic Care PCMH project, and by staff from

[30] Nutting Paul A., Miller, W. L., Crabtree, B. F., *et al.,* "Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home," *Annals Of Family Medicine*, Vol. 7, No. 3, May/June 2009

TransforMED on the transformation components that practices must follow to become a self-sustaining PCMH.

One of the most important issues facing the Workgroup was reaching consensus on a preliminary reimbursement scheme. The Workgroup and subgroups held several meetings in July and August. The reimbursement framework defined in the *Joint Principles for the Patient-Centered Medical Home*[31] calls for payment that appropriately recognizes the added value provided to patients who have a PCMH. Most medical home pilots do not precisely follow the specifications for payment endorsed in the *Joint Principles*, rather they have followed a blended model consisting of fee for service (FFS) plus a care management fee typically paid on a per member per month basis (PMPM). Many of the Workgroup members felt that Maryland should endorse cost efficiency measures that are included in the principles, but are not fully recognized in the payment approach. The Workgroup members believed that breaking the bonds between fee-for-service and delivery of care was desirable. Several approaches were considered, including the Prometheus[32] methodology and full capitation of care under the PCMH. Basing payments on chronic and acute episodes of care, as envisioned under Prometheus, was judged untested. Most Workgroup members felt that capitation would generate hostility in the provider community.

The Workgroup participants agreed that a shared savings model was an intermediate approach that would establish cost savings as an important priority. Under a cost savings model, a portion of reimbursement is based on savings that the provider can generate via avoided emergency department visits and reduced hospitalization. This payment methodology has been tested in the Physician Group Practice Demonstration in Medicare. In the Maryland's PCMH pilot, the practice would be reimbursed as usual for fee-for-service care. Payers would reimburse practices on a PMPM basis for care coordination expenses associated with the demonstration but not included in standard FFS. Bonus payments would be derived from the savings the payers were able to document, with approximately 75-80 percent of the savings returned to the practice. Practices would get the full payment if they are able to meet the cost and quality thresholds established for the program. A host of issues are yet to be worked out. In many shared savings models the payment baseline is an important point of discussion. The baseline can be the historical spending experience of the affected treatment population adjusted to the present using agreed upon inflation and age adjustment factors. Alternatively, the baseline could be a non-treated population that is similar along most dimensions, but not included in the pilot. Some practices expressed concern that the model could breakdown for very small practices, as year-to-year random variation could account for significant changes in cost levels even when practice performance was high in these settings. The Workgroup members recognized that much detail needed to be worked out and that a technical assistance consultant familiar with these models should be engaged.

Timeline

The Workgroup developed a Timeline and identified major cost components of the pilot. The Timeline assumes that planning would continue through 2009 and into 2010. Payers would make a commitment to participate in 2010. Once payer participation was confirmed, obtaining

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[31] Primary Care Patient Centered Collaborative, "*Joint Principles of the Patient-Centered Medical Home*," February 2007, available at http://pcpcc.net/content/joint-principles-patient-centered-medical-home

[32] PROMETHEUS Payment® Inc (Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability), available at: http://www.prometheuspayment.org/index.html

practice participation would begin. Practice PCMH awareness symposia would be sponsored by the State and other pilot participants in June and July of next year. At a minimum, practices would be required to meet NCQA PPC-PCMH level I recognition requirements to qualify for the pilot. Some transformation expenses would be financed by the pilot. The pilot will begin in January 2011 and transition over the next three years. At the end of the three years, the State will conduct an evaluation of the pilot. Payers may independently determine if they wished to continue utilization of the PCMH model.

Timeline and Major Milestones for Maryland's Patient-Centered Medical Home Pilot

Steps/Milestone	**Start**	**Duration, in Months**
Council endorsement of PCMH Pilot	Dec-09	1
Apply to CMS and AHRQ for waivers, participation, and funding	Dec-09	6
Propose legislation and enact statutory changes	Jan-10	5
Implement outreach plan for recruitment of participating practices	June-10	4
Practice Transformation implementation contract award and technical assistance	Jul-10	42
Qualified practices enroll eligible patients using commonly approved attribution rules	Sep-10	36
Practices begin medical home service delivery. Payers begin medical home payments using enhanced FFS + PMPM	Jan-11	12
Transition Practices to Shared Savings model (Yr 2)	Jan-12	12
Transition Practices to full implementation of Shared Savings model (Yr 3)	Jan-13	12
End Demonstration, Create Final Report	Dec-13	5
Council action on Final Report recommendations and Council decision to go forward	May-14	

Cost

The Workgroup began to categorize components of costs. As a number of important variables are not known at this time, it is not feasible to estimate an absolute cost for the pilot project. The most important driver of costs will be the number of practices that are participating. Funding for the pilot will not be easy. In this difficult time, most organizations are looking to conserve capital, not expend more on new initiatives. The potential benefits of PCMH are significant to all stakeholders. The Workgroup members believe that when the costs are carefully balanced against possible gains, private payers, Medicaid, possibly Medicare, purchasers, Maryland government, and consumers will agree that the expense is worth the risk.

Estimated Practice Costs Associated with Becoming and Maintaining a Medical Home

Description	Cost Range	Notes
One-Time/Periodic Start-Up Infrastructure Costs		
Practice Transformation	$5,000-$60,000 per practice, depending on implementation	Dependent on current state of a practice, includes staff education, consulting, some physical plant expansion. **Financing high-end costs are not sustainable in a large-scale roll-out.**
Upfront capital costs -- EHR acquisition costs	$7,000-$35,000 per physician	National HITECH and Maryland incentives contingent on 'meaningful' use could absorb majority of initial costs.
NCQA Recognition Costs	$800-$3,000 per practice	Varies depending on whether only recognition or readiness costs are financed.
Ongoing Costs		
Medical Home Costs typically rolled into PMPM	**$**3.00-$8.00 (max)	Most multi-payer demonstrations tend toward a PMPM at the lower end. Covers integrated care planning, dev. of care plan, RX medication and OTC reconciliation and tracking 7-days per week, 24-hour access to phone triage, ongoing staff training, physician oversight of clinical staff, software maintenance costs, patient education costs, and expanded professional liability insurance. No risk differentiation
Communication/coordination of care provided by a Care Coordinator(CC)	About .3-.5 CC per FTE physician – assumes that a CC earns $65K-$70K	Multi-payer pilots break this out separately from PMPM. Factors -- concerns about size of PMPM and how RN nurse coordinators are provided. Some demos envision using community-based CCs or payer-employed CCs, which could lower costs. CMS' CC rolls into PMPM.

At the August 26th meeting, the Workgroup agreed to submit 11 recommendations to the Council. Each of the recommendations is discussed individually below. Important areas of consensus and disagreement are noted in the discussion sections.

Recommendation 1: What is a medical home? A patient-centered medical home is a model of practice in which a team of health professionals, guided by a personal physician, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner throughout a patient's lifetime. The PCMH, accessible to all Marylanders, provides for all of a patient's health care needs, or appropriately collaborates with other qualified professionals to provide patient-centered care through evidence-based medicine, expanded access and communication, care coordination and integration, and care quality and safety. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues, within their practice, or through the coordination with other providers.

Discussion: The Medical Home Foundations subgroup began with consideration of the Patient-Centered Primary Care Collaborative's definition of the medical home: "an approach to comprehensive primary care for children, youth and adults—a health care setting that facilitates

partnerships between individual patients and their personal physicians and, when appropriate, the patient's family."

Consensus of the participants was that the definition should include the fundamental concept that comprehensive primary care includes all patients and places emphasis on the role of the patient's family and community, as well as emphasizing the collaborative approach to the provision of care which is culturally and linguistically appropriate. The medical home should meet the patient's health care needs throughout life, appropriately arranging for coordinated and integrated acute, chronic, preventive, and end of life care across all elements of the health care system, including subspecialty, hospitals, home health, nursing homes, and community resources, facilitated by registries and other information technology.

Recommendation 1.1 Goals of the Medical Home Workgroup members determined that Maryland's goals for the patient centered medical home include greater patient and provider satisfaction, greater patient access to providers, more comprehensive, coordinated preventive care and disease management resulting in lower rates of hospitalization, unnecessary office and emergency department visits and diagnostic tests when less expensive tests or treatments are equally effective and reduce patient safety risks and ultimately, lower costs.

In setting goals for Maryland's Medical Home pilot, the Workgroup considered and expanded upon the medical societies' joint principles, including:

1. Personal physician. . . an ongoing relationship, first contact, providing continuous and comprehensive care.
2. Physician-directed medical practice leads a team who collectively takes responsibility for ongoing care, with close integration of the PCMH with a network of specialties creating a medical neighborhood for the patient and the PCMH. (This concept is recognized, but not explicit in the core Joint Principles and is now thought to be critical to the success of a PCMH).
3. Whole person orientation . . . providing for all of the patient's health care needs, appropriately arranging care with other professionals, care for all stages of life, acute, chronic, preventive, and end of life. Patient-centered engagement and participation in care and decision-making are key to a demonstration. The National Quality Forum explicitly emphasizes listening to "the patient voice" and "organizing around the patient journey" regarding the experience of care across the continuum of care for that person, not just for discrete episodes of care.
4. Care coordinated/integrated across all elements of the complex care system . . . including, subspecialty, hospitals, home health, nursing homes, community resources, facilitated by registries, information technology, to get patients care when and where they need and want it in culturally and linguistically appropriate manner .
5. Quality and safety. . .support optimal, patient-centered outcomes, defined by care planning, driven by partnership between physicians, patients, family, evidence-based medicine and decision-support tools, continuous quality improvement, performance measurement, patients actively participate in decision-making, and quality improvement at practice, information technology to support care, performance measurement, patient education, and communication . . . voluntary practice recognition, to demonstrate capabilities to provide services consistent with medical home model.
6. Enhanced access to care . . . through systems such as open scheduling, expanded hours, and new options for communication between patients, personal physician, and practice staff.

7. Payment that appropriately recognizes added value . . . care management outside the face-to-face visit, separate FFS for face-to-face, coordination of care within a practice and between consultants, ancillary providers, and community resources, adoption and use of health information technology, enhanced communication such as secure e-mail and telephone. . . remote monitoring of clinical data, recognition of case mix differences, allow physicians to share in savings from care management in office, payments for measurable and continuous quality improvements.

Recommendation 2: Which Patients are Eligible? All patients are eligible. The Workgroup recognizes that chronically ill patients and their families will be an important focus as care improvements and cost savings on this group are most likely to be most significant.

Discussion: Participants strongly favored a broad-based model for the pilot program in order to encourage greater provider participation, rather than a chronic care model focused upon management and treatment of those patients having specific diseases. Workgroup participants representing Maryland's payers particularly argued for including all patients; however some felt that the focus of the pilot was on chronic care. Pediatricians felt that a model limited to chronic care patients was too narrow and would exclude most pediatric practices. In addition, Workgroup participants said that an assurance that all patients have a medical home should be included. This principle assumes that an individual has a physician. There should be an explicit goal to encompass population-wide enhanced access to care.

Recommendation 3: How will Practices be Recognized? Use NCQA's recognition model, require Level I PPC-PCMH then migration over a defined period to at least Level II PPC-PCMH (requires an EHR).

Discussion: Medical homes incorporate important structural attributes. How well they achieve the critical provider behaviors needed for medical homes to achieve their intended purposes is the purpose of NCQA recognition. Such understanding will also facilitate prioritization of the many changes that practices are being required to undertake in medical home projects to make effective use of the limited funds available.

Without a firm foundation in all four core attributes of primary care, the medical home may achieve short-term economic savings from reduced utilization of facilities, but is at risk of failing to achieve the goals of healthier populations, sustained long-term cost efficiency, and value for patients, providers, employers, and communities.

Recommendation 4: Which Physician Practices Are Eligible? Adult primary care and pediatric practices that endorse the Joint Principles as adapted to Maryland and can attain NCQA Level 1 recognition.

Discussion: The Workgroup considered several alternative approaches for defining practices. Members of the Workgroup that preferred to focus on specific expensive conditions favored selecting practices that were largely responsible for treating those patients. Representatives from the pediatric community argued that such a requirement would largely exempt pediatricians from participating as these practices seldom have significant numbers of chronically ill patients. Some advocates of primary care emphasized that traditional primary care practices were in crisis – the pilot should be principally aimed at them. FQHCs noted that they were already meeting many of the PCMH functions and suggested that focusing a demonstration on FQHCs would enable the state to assess the benefits of the PCMH model at relatively low cost.

The consensus of the group was that most of primary care was in crisis. Focusing on one segment or another would not allow for fully testing the robustness of the model across primary care settings. Practices should be included that could qualify as a PPC-PCMH level 1 or higher and were willing to commit to the principles of PCMH.

Recommendation 5: Who can lead a Medical Home Practice? A PCMH team may be led by a nurse practitioner, as permitted under Maryland law.

Discussion: The Workgroup discussed whether the PCMH team could be led by a nurse practitioner. There was unanimity that nurse practitioners were key elements of the team. Pilots sponsored outside of Maryland have used different approaches. The CMS PCMH demonstration that is planned has been limited to physicians. However, several state multi-payer PCMH demos, including Vermont, have included nurse practitioners. Representatives from several payers observed that they had no objection to a nurse-practitioner led PCMH. However there was general agreement that the Workgroup was not the forum for broadening any provider's scope of practice. Under current Maryland law, a nurse practitioner may practice independently if a collaborative agreement exists between the nurse practitioner and a physician.

Recommendation 6: Which Payers Should Participate? All major private payers (Aetna, CareFirst, Coventry, UHC) and Medicaid.

Discussion: The Workgroup discussed options for including all payers active in the Maryland market. That approach would ensure that costs of the pilot could be distributed proportionate to market share in the state. Including all private payers would provide the greatest incentive for practices. Including the largest subset of payers would increase the likelihood that a practice would be compensated (i.e., eligible for enhanced payment) for treating any potential medical home patient.

The Workgroup tried to balance efficiency with a need for payers to share the burden. The Workgroup recognized that even with full private payer participation, a significant share of patients could not be included because they would not meet attribution standards or were unwilling to commit to using a PCMH. Private payers with small market share in Maryland might suffer disproportionately higher costs if they were to participate. It was also observed that Kaiser Permanente operates a closed panel. That payer was unlikely to experience much benefit from participation. The Workgroup concluded that including the four largest payers would capture the payers that are primarily responsible for providing insurance benefits in Maryland.

There are thought to be special challenges for operating PCMHs for Medicaid patients under a Section 1115 waiver program.[33] Medicaid programs participate in multi-payer demonstrations in a host of states; however, few of these states have 1115 waiver programs. Three states do have waivers, including Connecticut, Rhode Island, and Washington. All of those states pay

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[33] Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to substantially test new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis.

capitation payments to Managed Care Organizations (MCOs) that deliver a comprehensive set of benefits, including primary care. Oklahoma pays capitation payments to practices for delivering primary care; however, it plans to transition to a fee for service PCCM program with a variable case management payment. Among these four states, Rhode Island pays financial incentives to MCOs that achieve specific performance benchmarks that indicate the presence of a functioning medical home, such as having PCP telephone access after business hours, and a percentage of children receiving well-child visits. The other three states are developing such programs. It is possible that the Maryland Medicaid program would have to seek approval from CMS to participate in the pilot. Despite the possible challenges, Workgroup members believe that Medicaid participation is essential.
The Workgroup concluded that the four largest payers plus Medicaid participation would ensure sufficient payer participation.

Recommendation 7: How Will Physician Practices Apply and Become Enrolled? The unit that applies will be the practice. Not all physicians in a practice will be required to join the application, and some practices may have physicians who are not eligible to join. If a practice is eligible, the implementation contractor will certify the capabilities of the practice and determine if the practice qualifies.

Discussion: This approach is consistent with the approach followed in other pilots. Although it is preferable that all providers in a practice participate in the pilot, physicians are organized in variety of legal configurations and sizes. Some organizations, as conditions of participation in the corporation, allow individual participants discretion in determining with whom they contract. In a multi-specialty practice, most specialists will not be able to participate because they are not providing primary care.

Recommendation 8: How Will Pilot Sites (areas) Be Selected? The Workgroup endorses the establishment of pilot sites so that a wide variety of practice configurations can participate, including solo and group practices, FQHCs, and faculty practices in both rural and urban parts of the state.

Discussion: Maryland should select sites, recruit practices, and determine which practice applicants are qualified to function as a medical home by July 2010. Upon practice qualification, through December 2010, participating practices will enroll eligible patients in the demonstration. Practices will begin operating as a medical home, and payers will begin to make medical home payments, in July 2011. The pilot will end in December 2013, with the evaluation of the pilot continuing for another year.

Recommendation 9: How will patients be attributed to a Practice? Patients will be attributed to a PCMH based on where the patient received the plurality of E&M services in the last two years. The participating physician will be responsible for enrolling his or her eligible patients. The physician will explain to the patient what a medical home is and its benefits.

Discussion: UnitedHealthcare has been using a two year look-back for the last few years on a number of different PCMH pilots. Two years of both medical and pharmacy claims help determine attribution. PMPM payments are not risk adjusted for any of the pilots, except by line of business. So, Medicare in one of the pilots is a multiple of the commercial, but Medicaid is somewhat less than the commercial. But in other pilots, the PMPM tiers up based on the NCQA level. It's not risk adjusted based on the patients' individual demographics or utilization. Aetna's perspective was that it is important that it is mapped out exactly how the attribution is going to

occur so that it is equitable among all of the plans.

Recommendation 10: How Are Participating Practices Reimbursed? Follow Joint Principles on payment in phase 1 (year 1). Maintain PMPM, but transition practices to a shared savings approach by year 3 with no penalty for losses.

The payment subgroup recommended reimbursement for the first tier: FFS, plus an EHR acquisition payment over time, plus a PMPM, plus pay for quality. For the second tier: a FFS, plus a PMPM, plus pay for quality or pay for performance, and shared savings. The evaluation of the savings would begin at year 2 and look back over an entire two year period for where there are savings that could be then distributed. An evaluation would not be made until the end of the second year, and then going forward, a look back over the prior two years to determine the savings and distribute them.

Discussion: This recommendation generated a significant amount of debate. Workgroup members endorsed the shared savings model. Members voiced some differences on how quickly a shared savings model should be implemented. One group that supported a slower transition emphasized the multiple goals of a PCMH pilot which include improving clinical care process, increasing access to care coordination, enhancing patient experience of care, increasing clinician work satisfaction, and lowering the total cost of care. They further argued that that the current model of primary care is no longer sustainable. Overemphasizing the need for cost savings minimizes the complex changes that must occur. In a PCMH pilot, practitioners must change support staff, redesign practice management, modify their own clinical decision-making, educate patients, deploy new communication initiatives, and launch a health technology project. Given the complex interventions and the short (three-year) time horizon, linking the success of the pilot to achieving cost savings minimizes the importance of other outcomes.

A second group focused laser-like on the cost savings opportunities. They argue that a principal goal of the pilot and the reimbursement criteria that underpin it is to incent practices to reduce total costs. They believe that the goal of shared savings should be stated clearly up front and a payment underlying shared savings should be implemented as rapidly as practicable, so that practices would organize themselves from the outset not only to improve quality and continuity of care, particularly for chronic illnesses, but also explicitly reduce ED and hospital usage. These advocates bemoan most PCMH proposals that aim to defray the costs that practices incur in transitioning to and operating a medical home model by providing funding for additional staff and for practice reengineering with no front-end commitment from practices to reduce costs. Although they concede that these incentives may encourage early initiators to change their practice style and improve outcomes, they are pessimistic that these incentives are sufficient to engage the broad range of practices for whom current practice patterns are good enough and for whom change would be costly in time and energy, with no assurance of adequate rewards, whether they be monetary or professional.

This group's greatest fear is that introducing medical home pilots without major payment reform will improve care and satisfaction but will cost more than current care, not less. Without explicitly incentivizing reductions in ED use and hospitalizations – or reductions in total costs of care – savings may be insufficient to offset the additional costs of the medical home, making continuation of the project a harder sell to payers and purchasers.

Recommendation 11: What are the measures of success? In the short-term, improved quality of care and improved patient/physician satisfaction. In the long-term, improved cost

efficiency in the system is essential if the PCMH model is to be self-sustaining.

Discussion: Workgroup participants noted that care coordination goals would need definition and established criteria for measurement. Discussion focused upon including a shared savings model for physician practices and payers. One issue to be considered regarding shared savings is how to deal with instances where there are no shared savings, but payments for primary care will have at least shifted away from, perhaps, facilities and avoidable acute care, to primary care. Most physician practices would prefer to determine the best way to allocate care coordination fees. Shared savings may not be evident for several years. There was additional discussion of an audit process and about what a formula would be as the practice improves. Pay for performance begins with a payment for quality, but evolves to a payment for quality and efficiency. Many of the demonstrations, including CareFirst's, start with a reward for quality improvement and then inject some efficiency measures at stage two. The definition of the efficiency measures is tied to a cost metric. A shared savings model would provide a proportional, and possibly larger, reward back to the practices. Most of the New England demonstrations have opted to carve out the care coordination from the PMPM.

Workgroup participants also concluded that increasing the number of success measures also increases the costs of the pilot.

Recommendation 12: What form of State action is required to reassure payers to participate?

As discussed above, the Council and Workgroup staff have been advised by Maryland Assistant Attorneys General that existing Maryland law poses a number of challenges for establishing a Pilot. First, the Executive Order establishing the MHQCC does not provide sufficient anti-trust protections. Second, the Maryland Insurance Article limits the use of capitation to HMOs and requires that performance bonuses be based on quality. Third, Maryland law requires carriers to obtain patient consent before sharing data with other providers, even those on the same PCMH care team. Last, current Maryland law offers no solution to engaging self-insured employers in state PCMH initiatives. A change in Maryland law is necessary for Maryland State employee benefits plan beneficiaries to participate in the PCMH pilot. The staff recommends that MHQCC endorse legislation to establish a PCMH pilot in Maryland.

Discussion: Staff makes this revised recommendation to the Council. Assistant Attorneys General from the Maryland Insurance Administration (MIA) and the Department of Health and Mental Hygiene (DHMH) have provided interpretation of current law and recommended statutory changes in the Maryland Insurance Article and the Health General Article. Staff will complete a draft and identify legislative sponsor(s) in December 2009.

WORKGROUP BENCHMARKS AND TIMELINE

Wellness and Prevention Benchmarks – Healthiest Maryland Businesses:
By **March 2010**, identify and recruit ambassadors to champion the program and assist with recruitment.
By **April 2010**, launch business recruitment and assessment tool, reaching 75 businesses and 50,000 employees in 18 months.
By **June 2010**, initiate implementation of policies that promote healthy choices in businesses throughout Maryland.
By **April 2011**, establish a recognition mechanism with the Office of the Lieutenant Governor for partner businesses that have made successful changes to improve their healthy business environment.

Evidence-based Medicine Benchmarks – Hand Hygiene:
By **January 1, 2010**, initiate the Maryland Hospital Hand Hygiene Collaborative; implement the collection of the Maryland Hand Hygiene Core Data Set at Maryland acute care hospitals using trained observers whose task is unknown to the staff being observed to collect data on adherence to hand hygiene; and, provide feedback to participating hospitals with Maryland performance benchmarks.
By **July 1, 2010**, identify on-going funding to support the key activities of the prevention collaborative.
Evidence-based Medicine Benchmarks – Blood Wastage:
By **January 1, 2010**, achieve 100% participation among all Maryland hospital blood banks and set the Collaborative's waste reduction targets.
By **June 2010**, present findings and strategy to expand blood wastage reduction efforts Statewide.

Patient Centered Medical Home Benchmarks:
Introduce a bill by **February 1, 2010** with commitments of support from all major stakeholders. Statutory change is anticipated to become law by **July 1, 2010**.
By **May 1, 2010**, reach agreement on payment methodology and quality measures.
By **June 1, 2010**, execute agreements with Medicaid MCOs, with at least 2 MCOs agreeing to participate in PCMH demonstration program.
Hold statewide symposia beginning **June 15, 2010**.

IV. Appendices

APPENDIX A: WORKGROUP MEMBERS AND MEETING DATES

Wellness and Prevention Workgroup

Council Members
Jill Berger
Debbie Chang
James Chesley
Roger Merrill
Peggy O'Kane
E. Albert Reece
Reed Tuckson

Staff
Fran Phillips (Chair – Secretary's Designee)
Nyasha Bakare
Orion Courtin
Mark Humphrey
Maria Prince
Audrey Regan
Nicole Stallings

Other Participants
Geff Bergh (Merck)
Amy Deutschenberg, Johns Hopkins
Lori Doyle, Community Behavioral Health Association
Allison Gertel-Rosenberg, representing council member Debbie Chang
Carmela Jones, Jeanne DeCosmo and Jessica Jackson, Maryland Hospital Association
Alan Lake, Maryland chapter of American Academy of Pediatrics
Adam Milam, representing Delegate Tarrant
John Miller, Mid-Atlantic Business Group on Health
Deb Neels, Patty Ilowit, and Mary de la Santo, University of Maryland
Amjad Riar, Capitol Palliative Care Consultants
Magaly Rodriguez deBittner, University of Maryland School of Pharmacy
Nancy Witkowski, Boehringer Ingelheim Pharmaceuticals

Wellness and Prevention Workgroup Meeting Dates

January 30, 2009
March 2, 2009
May 26, 2009
September 18, 2009

Evidence-based Medicine Workgroup

Council Members
Chip Davis (Chair)
Jill Berger
James Chesley
Barbara Epke
Leslie Simmons
Kathi White

Staff
S. Orion Courtin
Mary Mussman
Nicole Stallings

Other Participants
Pam Barclay, MHCC
Bev Miller, Maryland Hospital Association
Bill Minogue, Maryland Patient Safety Center
Dianne Feeney and Steve Ports, HSCRC
Maria Prince, DHMH
Janet Robinson, Delmarva
I-Fong Sun, Howard Carolan and Tracy Chang, Center for Innovation in Quality Patient Care at Johns Hopkins
Gwen Winston, OHCQ
Grace Zaczek, MCHRC

Blood Wastage Reduction Workgroup
Page Gambill, American Red Cross
Donna Marquess, LifeBridge Health
I-Fong Sun, Tracy Chang, Joan Boyd, Lisa Shifflett and Richard Hill, Center for Innovation in Quality Patient Care at Johns Hopkins
Janice Hunt, UMMC
William Minogue, Maryland Patient Safety Center
Mary Mussman, DHMH

Evidence-based Medicine Workgroup Meeting Dates

January 30, 2009
February 17, 2009
March 13, 2009
April 15, 2009
May 5, 2009
May 29, 2009
June 4, 2009
June 25, 2009
July 16, 2000
Sept 2, 2009
Sept 18, 2009
October 29, 2009
December 1, 2009

Patient Centered Medical Home Workgroup

Council Members
Barbara Epke
Roger Merrill
Kathi White (Chair)

Staff
Ben Steffen
S. Orion Courtin
Karen Rezabek
Nicole Stallings
Grace Zaczek

Workgroup Participants from State Agencies
Rex Cowdry, MD, MHCC
John Folkemer, Maryland Medicaid
Kathy Francis, MHCC
Mel Franklin, MHCC
Robert Murray, HSCRC
Dan O'Brien, DHMH
Rebecca Perry, MHCC
Maria Prince, MD, DHMH
Tricia Roddy, Maryland Medicaid
Elizabeth Sammis, MIA
Susan Tucker, Maryland Medicaid
Suellen Wideman, MHCC
Brenda Wilson, MIA

Other Participants
Salliann Alborn, Maryland Community Health System
Kathie Baldwin, Mid-Atlantic Association of CHCs
Michael Barr, American College of Physicians
Tricia M. Barrett, NCQA
Geff Bergh, Merck
Chad Boult, Johns Hopkins, School of Medicine and Public Health
Carol Bloomberg, Bloomberg Associates
Kelli Brannock, Merck
Ron Carlson, Community Health Improvement
Sarah Reese Carter, DHMH
Johann Chanin, NCQA
Robb Cohen, LX Health
Barbara Cranston, NCQA
Nancy Creighton, PRMC
Colleen DeVaul, Merck
Cathy Doyle, CareFirst BlueCross BlueShield
Eva DuGoff, Johns Hopkins University, Bloomberg School of Public Health
Barbara Emanuel, Merck
Barbara Epke, Lifebridge Health
Scott Feeser, Johns Hopkins Medicine

Judy Fennimore, Marriott
Darlene Fleischmann, MedChi
Richard Fornadel, Aetna
Ray Granberry, AARP
Marti Grant, DHMH
Hank Greenberg, AARP
Sheila Higdon, Johns Hopkins Medicine
Christine Barbara Johnson, TransforMED
Dawn Johnson, ACS Government Healthcare Solutions
Jeffrey Kaplan, MedChi
Jack Keane, Consultant
Virginia Keane, University of Maryland, School of Medicine
Tracy King, Johns Hopkins School of Medicine
Richard Kritzler, Johns Hopkins Medical Institutions
Lisa B. Korin, Johns Hopkins University, Bloomberg School of Public Health
Edward Koza, United Healthcare
Tiffany Lundquist, AARP
Marc Malloy, Coventry
Elizabeth Menachery, Howard County Health Department
Edward Miller, MedStar Health
John Miller, Mid-Atlantic Business Group on Health
Susan Milner, NCQA
Deborah Neels, University of Maryland, Government Affairs
Judy Lee Nguyen, Merck
Mark Noveck, Coventry
Kevin O'Neill, CareFirst BlueCross BlueShield
Lois Oliver, CareFirst BlueCross Blue Shield
Lee Partridge, National Partnership for Women and Families
Lisbeth Pettengill, Greater Baltimore Committee
Carol Reynolds, Potomac Physicians, PA
Sheila Richmeier, TransforMED
Glenn Robbins, University of Maryland Medical Systems
Calvin Robinson, Holy Cross Hospital
Yvette Rooks, University of Maryland School of Medicine
Jon Shematek, CareFirst BlueCross BlueShield
Dale Shumaker, Rockburn Institute
Ramona Siedel, Bay Crossing Family Medicine
Eric Sullivan, United Healthcare
Susan Tucker, Maryland Medicaid
Mary Takach, National Academy of State Health Policy
Tia Torhorst, National Partnership for Women and Families
Pegeen Townsend, MedStar Health
Richard Walker, IBM Healthcare and Life Sciences
Karol Wicker, MHA, Center for Performance Sciences
Jay Wolvovsky, Baltimore Medical System

PCMH Workgroup Meeting Dates

March 9, 2009	PCMH Workgroup
March 17, 2009	PCMH Workgroup
April 6, 2009	PCMH Workgroup
April 24, 2009	Medical Home Foundations subgroup
April 27, 2009	Practice Transformation subgroup
May 4, 2009	Purchasers and Consumers Education subgroup
May 13, 2009	Practice Transformation subgroup
May 14, 2009	Medical Home Foundations subgroup
May 20, 2009	PCMH Workgroup
June 19, 2009	PCMH Workgroup
June 26, 2009	PCMH Workgroup
July 17, 2009	Payment subgroup
August 4, 2009	Payment subgroup
August 28, 2009	PCMH Workgroup
October 26, 2009	PCMH Workgroup
November 6, 2009	Transformation Quality Measures subgroup
November 20, 2009	Transformation Quality Measures subgroup
December 14, 2009	PCMH Workgroup

APPENDIX B

CHRONIC CARE MANAGEMENT PLAN STRAW MAN OUTLINE

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Actions (Activities and Systems Changes for Addressing Strategies)*
Promote a culture of wellness in the family, school, healthcare, and worksite setting	Community-based strategies to combat obesity and physical inactivity	Creating an environment that is supportive of eating healthy and fitness	**Physical Activity** Safe neighborhoods, communities, and buildings support physical activity Promote active transport (walking and biking) to school and work and access to recreation facilities Support quality physical education and physical activity in school and afterschool and physical activity in licensed childcare settings Decrease television viewing and sedentary activity Implement signage prompting use of stairs **Nutrition** Fresh, local, and healthy food is available and affordable in all communities and neighborhoods Comprehensive school nutrition policies including breakfast promotion; healthy lunch and snacks, including classroom celebrations and incentives, fundraising, concessions, vending; school gardens; farm-to-school initiatives Support breastfeeding through education, providing space and time for milk expression at work, and high-quality breast pumps	Assessment: Identify the best channels for reaching families and school/healthcare/employer leadership groups Assurance: Public awareness—Media campaign (VERB); Fruits and Veggies More Matters campaign; campaign emphasizing the benefit to the business community of a healthier population (based on Alliance to Make US Healthiest) Daycare/School—promoting implementation of coordinated school health model; CATCH; Planet Health or Eat Well, Move More; I Am Moving, I Am Learning for all daycares, school-based walking programs Healthcare—Provider & clinical staff education on promoting wellness for patients at-risk for or with chronic disease Community—Shape up Somerville or EPODE model; “We Can!”; Healthy Corner Stores; social support for walking Worksite—Sharing best practices in worksite wellness through MidAtlantic Business Group on Health, Greater Baltimore Committee, Maryland Chamber of Commerce, nonprofit health organizations, hospitals and payors; State worksite pilot as model public sector employer Policy: Comprehensive promotion of physical education, physical activity, and healthy eating in schools and licensed

			Comprehensive Employee wellness including health assessment with follow-up coaching; ongoing health education; and policies and environmental supports for healthy behaviors Healthcare providers recommend healthy eating and physical activity for all children and for patients at-risk for or with chronic diseases	childcare Incentives for grocery stores and farmers' markets to locate in low-access areas; Maryland Community Food Coalition Nutrition labeling on menus WIC food package changes Built Environment, as part of Plan Maryland, the State plan for growth and development (including health impact assessments in planning)

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhance access to multiple opportunities for patient self-management education for high-risk populations	Patient self-management	Engaging patients and families in managing their health and making decisions about their care	Patient participation in diabetes and/ other chronic disease self-management education Assess diabetic patients' status with self-management goal at each visit with a healthcare provider Multi-disciplinary, family-based childhood obesity treatment	Assessment: Identify the barriers and gaps in access to self-management education Assurance: Healthcare--Self-management education provided by pharmacists (P3 program); childhood obesity treatment Community--Stanford model Chronic Disease Self-Management Program; Community Health Workers (CHW) and health coaches Worksite--self-management education as part of health risk assessment and feedback; P3 at State Center for State employees Policy: Explore healthcare system or other sustainable financing for self-management education including prediabetes Explore financial incentives for patients to manage their own care

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhance infrastructure	Leveraging of public and	Ensuring that resources	Coordinate public and private initiatives throughout Maryland and with national	Assessment: Identifying public and private sector initiatives in childhood obesity, heart disease, cancer, stroke,

for statewide leadership and evaluation	private initiatives	are maximized	initiatives	COPD, diabetes, and other IOM priority areas; Assurance: Enhance public health infrastructure for coordinating chronic disease prevention efforts; promote Patient-centered Medical Home principles in collaboration with payors Policy: Coordination of community benefits provided by non-profit hospitals
	Data collection	Ensuring that all activities are data-driven	Benchmark Maryland data to national data Use the RE-AIM evaluation framework to evaluate progress and allow for course corrections (Reach, Efficacy/ Effectiveness, Adoption, Implementation, Maintenance)	Assessment: Produce a Chronic Disease Report Card for Maryland by consolidating disparate data bases with special attention to disparities, local differences, and diseases with common risk factors Assurance: Enhance public health infrastructure for assessment Policy: Standardization of data collection to permit aggregated analysis; promote Patient-centered Medical Home principles in collaboration with payors

Goals	HB 1395 Plan area	Objective	Strategies	Potential Strategic Activities and Systems Changes for Addressing Strategies*
Enhanced delivery of high-priority preventive services and care management	Dissemination of evidence-based information on prevention and treatment	Creating a healthcare system that prioritizes prevention and improves delivery of evidence-based treatment	Identify prediabetics and translate the Diabetes Prevention Program into practice for those with prediabetes Delivery of the underused high-priority preventive services including aspirin prophylaxis, colorectal cancer screening, and tobacco cessation Treatment to target for high blood pressure, high cholesterol, and diabetes Receipt of appropriate diabetes-specific	Assessment: Identify current rates of delivery of high-priority preventive services and treatments Identify current rates of aspirin use, blood pressure control, cholesterol control, diabetes control, eye screening, foot screening, goal-setting, and smoking among diabetics Assurance: Community or worksite—availability of DPP; CHW Healthcare—Expanding existing public health services to include screening and treatment for obesity, hypertension, dyslipidemia, diabetes Healthcare—Continuous Quality Improvement *Healthcare--Academic detailing at the primary care

			screening for diabetics (eye, feet)	provider practice level to implement Chronic Care Model *Healthcare—Improving medical education on high-priority preventive services and chronic care management Policy: promote Patient-centered Medical Home principles in collaboration with payors Coverage of evidence-based preventive services Coverage of therapeutic lifestyle change (DPP) for prediabetics
	Information technology that supports care management	Supporting care management through information technology	Use IT to implement patient and provider reminder systems Use technology to improve access to care Use IT to manage patient populations and target interventions	Assurance: *Healthcare—MHCC's CMS demonstration project for creating Health Information Exchange *Healthcare—Using IT infrastructure and care coordination to prevent rehospitalization and ER visits (Get With the Guidelines, explicit provider-to-provider handoff for care transitions) Worksite—Programs such as P3 use IT to promote coordination with Medical Home Policy: Promote Patient-centered Medical Home principles in collaboration with payors Telemedicine
	Linking financing mechanisms and performance measures	Providing incentives for evidence-based care	*Evaluate effectiveness of incentives for providers for providing evidence-based care	Policy: *Promoting Patient-Centered Medical Home principles in collaboration with payors (including incentives for delivering high-priority prevention services and chronic disease treatments)

APPENDIX C

EVIDENCE BASED MEDICINE WORKGROUP: POTENTIAL STRATEGIES

Maryland Health Quality and Cost Council – Time to Impact for Proposed Recommendations

Goal: Implement Evidence-Based Practices and Quality Improvement Initiatives with known cost-savings results State-Wide.

KEY

Time
Resources (FTE)
Expense
Impact
Political

Clinical Quality

1.Hand Hygiene

Intervention: JHH WIPES campaign
Impact:
Increase in Hand Hygiene Compliance by 300% (outcomes for avoided HAIs still under evaluation).
Cost: Literature demonstrates that operating costs = 1% of cost savings due to avoided HAIs
Ease of Implementation:

2. Hospital-Acquired Infections (HAIs)

Checklist
CR-BSI
SSI
VAP
MRSA

Intervention: Checklist(s)
Ease of Implementation: Behavioral Change

Catheter-Related Blood Stream Infection
Impact:
$35-56K additional cost per case
+10-24 days additional LOS; +15-35% attributable mortality

Surgical Site Infection
Impact:
$34K additional cost per case; +7-20 days additional LOS; +9% attributable mortality

Ventilator-Associated Pneumonia
Impact:
$52K additional cost per case; +8-14 days additional LOS; +20-30% attributable mortality

Methicillin-Resistant Staphylococcus Aureus (MRSA)
Impact:
$32K additional cost per case; +days additional LOS; +% attributable mortality

3. Door-to-Balloon Time (D2B)

Intervention:
Providing prior notification of arrival of STEMI patient to activate provider PCI response protocols
Impact:
Increase % of STEMI patients receiving treatment within 90 minutes of arrival; Nationwide it is known that fewer than half of STEMI patients receive primary PCI within guidelines
Cost: Transmitters, 12-Lead ECG, Receiver at provider site
Ease of Implementation:

4. Stroke Network (Telemedicine)

Intervention: Operationalizing a program already developed to allow rural hospitals the ability to receive feedback from specialists in urban hospitals (e.g., Johns Hopkins Hospital and UMMC) through a hub-and-spoke telemedicine network
Impact:
Improved access and equity of care; Reduce mortality and morbidity from stroke
Cost: Three different models to operationalize (models vary based on technology and scale): $400K –$ 1.2M
Ease of Implementation:

Efficiency

5. Blood Wastage

Intervention: Application of Lean Sigma Methodology to improve usage and storage of blood products
Impact:
Within first two years of project, JHH resulted in a savings of over 3,700 units of blood, which corresponds to a savings of $714,000 for the hospital.
Cost: Purchase of coolers and temperature readers
Ease of Implementation:

6. Application of Lean Sigma

7. HIPAA Standard Transaction Sets

Intervention: Implementation of HIPAA standard Transaction Sets
Impact:
Reduction in Denials, Increase response time, Increase in clean claims, Reduction in human touch points, Reduction in time for each step, Increased accuracy
Cost: System development and clearinghouse charges
Ease of Implementation:

TIME TO IMPACT | 1-3 MONTHS | 3-6 MONTHS | 6-9 MONTHS | 9-12 MONTHS | 12+ MONTHS

APPENDIX D

HEALTHCARE-ASSOCIATED INFECTION ACTIVITIES OVERVIEW: MHCC AND THE HAI ADVISORY COMMITTEE

Background

Healthcare-associated infections (HAI) are infections that patients acquire during the course of receiving medical treatment for other conditions. HAIs are the most common complication affecting hospitalized patients, with between 5 and 10 percent of patients acquiring one or more infections during their hospitalization.

In 2006, the General Assembly amended the MHCC's statute to give it authority to collect and report information on healthcare-associated infections in hospitals. HG 19-134(e)(6). Certain information on HAI process measures are publicly reported for each Maryland hospital in the Commission's *Maryland Hospital Performance Evaluation Guide* (http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm). As discussed below, information on additional quality measures is being collected and will be reported.

The Commission convened an HAI Technical Advisory Committee (TAC) composed of hospital infection preventionists, hospital epidemiology, public health professionals, and patients/health care consumers. In December 2007 the TAC released a report, *Developing a System for Collecting and Publicly Reporting Data on Healthcare-Associated Infections in Maryland*, that may also be accessed on the website: http://mhcc.maryland.gov/healthcare_associated_infections/index.html. The MHCC has been implementing the recommendations of its TAC in stages.

Healthcare-Associated Infections Advisory Committee

To guide the implementation of HAI public reporting , the TAC recommended that the Commission establish a permanent standing HAI Advisory Committee consisting of representatives from acute care hospitals, long term care facilities, ambulatory surgery centers, freestanding hemodialysis centers, Society of Healthcare Epidemiology of America (SHEA) and Association for Professionals in Infection Control and Epidemiology, Inc. (APIC). In addition, the TAC recommended that the Advisory Committee have at least one of each of the following: a hospital epidemiologist, an infection prevention and control professional, a public health specialist, a public health lawyer, a statistician, an ethicist, quality improvement/patient safety expert, and a patient/health care consumer.

The Commission took steps to establish a standing HAI Advisory Committee in early 2008 by inviting key stakeholder organizations to nominate representatives. The stakeholder organizations contacted included: APIC (both the Washington, D.C. and Metropolitan Baltimore Chapters); CareFirst Blue Cross and Blue Shield; Department of Health and Mental Hygiene; Health Facilities Association of Maryland; LifeSpan; Maryland Ambulatory Surgery Association; Maryland Hospital Association; Maryland Patient Safety Center; and, SHEA. The Advisory Committee began meeting in the spring of 2008 and has since met on a monthly basis

to develop and implement plans for collecting and reporting HAI data.

Key Advisory Committee activities are highlighted below:

Surgical Care Improvement Project. In 2006-07, the Commission began collecting and reporting HAI information on three process measures designed to prevent infections for patients undergoing hip, knee, and colon surgery: (1) proportion of patients receiving antimicrobial prophylaxis within one hour prior to incision (SCIP-INF-1); (2) proportion of patients receiving the appropriate antimicrobial agent based on current guidelines (SCIP-INF-2); and, (3) proportion of patients whose antimicrobial prophylaxis is discontinued within 24-hours following surgery (SCIP-INF-3). These measures, referred to as Surgical Care Improvement Project (SCIP) measures, have been endorsed by the National Quality Forum (NQF) and adopted by the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and Hospital Quality Alliance (HQA). As of January 1, 2009, the MHCC expanded its collection of SCIP INF 1-3 measures to include all surgical strata (CABG, other cardiac, hysterectomy, and vascular surgery). The MHCC added additional SCIP measures, effective for discharges after January 1, 2009: cardiac surgery patients with controlled 6 a.m. postoperative serum glucose (SCIP-INF-4); surgery patients with appropriate hair removal (SCIP-INF-6).

Central Line-Associated Blood Stream Infections (CLABSI). Pursuant to Health General Article §19-134(e)(6) and COMAR 10.25.04, Maryland hospitals began reporting CLABSIs in All Intensive Care Units (ICUs) to the Commission using the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) system effective July 1, 2008. This reporting requirement, which covers 46 of the 47[34] non-Federal, acute care hospitals located in Maryland, encompasses inpatient adult critical care units, pediatric critical care units, and neonatal critical care units (including Level II/III and Level III). Data reported for fiscal year 2009 will cover about 1,200 intensive care unit beds and 400 neonatal intensive care bassinets. Hospitals are required to report data on a monthly basis to the Commission.

Surgical Site Infections. Surgical Site Infections (SSI) are part of the Phase II data collection plan recommended by the HAI Technical Advisory Committee. The Technical Advisory Committee recommended that data collection and reporting of SSIs focus on Class I (clean) or Class II (clean contaminated) surgeries. Over the past several months, the HAI Advisory Committee has worked to identify surgeries that should be included in the SSI implementation plan. Because surgeries chosen to be reported must be performed with adequate frequency to permit meaningful comparisons between institutions, the Advisory Committee has reviewed hospital-specific data on the volume of surgery cases by category. In addition, the Committee reviewed information on hospital infection prevention and control practices involving surgical services. Data collected in the Commission's 2009 annual survey of infection prevention and control practices indicate that a large proportion of hospitals currently perform surveillance on SSIs. About one-half of Maryland hospitals report that they are currently using or have future plans to use NHSN for SSI surveillance. Of those hospitals, hip and knee replacement surgery were the most frequent surgeries included in SSI surveillance. Based on this review and analysis,

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[34] One Maryland acute care hospital, McCready Memorial Hospital, does not operate an intensive care unit and has been exempted from this reporting requirement.

the Advisory Committee recommended that SSI work initially focus on hip replacement, knee replacement and coronary artery bypass graft (CABG) surgeries. The Advisory Committee is currently reviewing public comments received on this recommendation.

Multi-Drug Resistant Organisms. As recommended by the Technical Advisory Committee, a plan for reporting AST for MRSA in ICUs has been developed and implemented. Effective January 1, 2009, Maryland hospitals are required to collect data on Active Surveillance Testing (AST) for MRSA in ICUs, including all units defined as inpatient adult critical care and pediatric critical care (neonatal intensive care units are excluded from this reporting requirement). Hospitals are reporting data on the total number of ICU admissions and the number of patients admitted to the ICU who had an anterior nares swab cultured for MRSA on a quarterly basis using an online survey instrument. Data for the first quarter of 2009 (January 1, 2009 - March 31, 2009) was reported to the Commission on May 1, 2009. During June 2009, each hospital received a report that provides their AST data (total ICU admissions, admissions with anterior nares swab cultured for MRSA, percent of total ICU admissions with AST) and benchmark data reflecting the average statewide proportion of ICU admissions with AST for MRSA, and the average for the top five and lowest five hospitals. Data for the second quarter 2009 (April-June 2009) was reported to the Commission on August 1, 2009.

Health Care Worker Seasonal Influenza Vaccination. For the 2008-2009 reporting period, the Commission conducted a pilot survey to determine the feasibility of collecting uniform data on HCW influenza vaccination rates. In this pilot survey, Maryland non-Federal, acute care hospitals were requested to report aggregate data on all paid, full-time and part-time employees and house staff (defined as residents and interns) who received FluMist® or injectable flu vaccine on-site or off-site between October 1, 2008 and March 31, 2009 using on on-line survey. All Maryland hospitals participated in this pilot survey. During June 2009, each hospital received a report that provided their HCW influenza vaccination rate data (total employees, employees who received flu vaccine, and percent of total employees receiving flu vaccine) and benchmark data reflecting the average statewide proportion of staff receiving the flu vaccine and the average for the top five and lowest five hospitals. Based on the pilot survey experience, the HAI Advisory Committee revised the survey instrument for the 2009-2010 reporting period. Data collection for the 2009-2010 reporting period is currently underway and will be publicly reported on the Maryland Hospital Performance Evaluation Guide in July 2010.

APPENDIX E

SUMMARY OF CDC FUNDING AWARD

Reducing Healthcare Associated Infections in Maryland

Epidemiology and Laboratory Capacity for Infectious Diseases

Cooperative Agreement Period: August 30, 2009 – December 31, 2011

The Maryland Department of Health and Mental Hygiene, Infectious Disease and Environmental Health Administration, in partnership with the Maryland Health Care Commission, was awarded funding from the Centers for Disease Control and Prevention in support of the surveillance and prevention of healthcare associated infections (HAIs). Funds provided for the 28 month funding period cover personnel salaries for three full-time and two half-time staff members, fringe benefits, external validation of the data collected via the NHSN, and initiation of two prevention collaboratives. Activities include:

Activity A - Coordination and Reporting of State Healthcare Associated Infections Prevention Efforts

The State of Maryland will develop a *Healthcare Associated Infections Prevention Plan* to serve as the overall guiding document for Maryland's efforts to coordinate and implement activities designed to prevent (HAIs) and to monitor progress in achieving prevention targets. The *Plan* will be consistent with the federal Department of Health and Human Services national Action Plan for reducing HAIs. Specific activities include:

- Restructure the existing HAI Technical Advisory Committee to add stakeholders representing key State agencies and other appropriate organizations.
- Establish HAI Technical Advisory Committee subcommittee structure to guide key components of the HAI Prevention Plan.
- Prepare and adopt proposed Maryland HAI Prevention Plan and submit to the Secretary of Health and Human Services by January 1, 2010.
- Prepare and adopt final Maryland HAI Prevention Plan.
- Monitor and communicate progress in meeting defined HAI prevention targets on a quarterly basis.

Activity B - Detection and Reporting of Healthcare Associated Infection Data

Based on the adopted *HAI Prevention Plan*, Maryland will undertake activities to expand key HAI data sets, develop and implement data validation and training programs, initiate electronic laboratory reporting from five Maryland hospitals to the National Healthcare Safety Network (NHSN), and analyze and report HAI data submitted to the NHSN. Specific activities include:

- Effective January 1, 2010, expand HAI data reporting requirements for Maryland hospitals to include hip replacement, knee replacement and coronary artery bypass graft surgical site infections using NHSN.
- Develop training program for Surgical Site Infection (SSI) data collection for new users.

- Develop and implement protocol for data quality review and validation of Maryland hospital SSI data; provide feedback regarding HAI data validation results and discuss NHSN user technical questions.
- Develop user friendly display format for publicly reporting hospital-specific Central Line-Associated Blood Stream Infections (CLABSI) and SSI data on the Maryland Hospital Performance Evaluation Guide.
- Expand HAI data reporting requirements for Maryland hospitals to include multi-drug resistant organisms (MDRO) for all Maryland hospital intensive care unit patients, including adult and pediatric inpatient critical care units and neonatal critical care units, using NHSN.
- Develop and implement protocol for validation of MDRO data.
- Develop training program for MDRO data collection to orient new users; provide feedback regarding HAI data validation results and discuss NHSN user questions.
- Develop a plan for electronic laboratory reporting from five Maryland hospitals to NHSN and NEDSS by leveraging the MSS technology to satisfy both reporting requirements.

Activity C - Establish a Prevention Collaborative

With the Maryland Patient Safety Center establish two prevention collaboratives. The NHSN will be used to collect baseline data and monitor progress towards the collaboratives' goals. The collaboratives are:

1. Hand Hygiene Prevention Collaborative: Stated as a priority by the Healthcare Associated Infections Technical Advisory Committee and the Governor's Health Quality and Cost Council.

2. MDR-Acinetobacter/MDRO Prevention Collaborative: Work with the acute care hospitals in the Baltimore Metro Area and the local hospital and infection control associations and other stakeholders to establish a prevention collaborative to reduce the incidence and impact of infections due to multi-drug resistant Acinetobacter. Efforts can be expanded to include other multi-drug resistant organisms.

APPENDIX F

REDUCTION OF BLOOD WASTAGE COLLABORATIVE: SUMMARY OF PARTICIPATION

Current as of 12/8/09

	07/22 Meeting	09/22 Call	Baseline Data	Pledge Rec'd	Database Training	Website reg	10/09 Data
American Red Cross	X	X	NA	NA	X	NA	NA
Anne Arundel Medical Center			X	X	X	X	X
Balt/Wash Med Ctr		X	X	X	X	X	X
Blood Bank of Delmarva		X	NA	NA	X	NA	NA
Bon Secours			X	X	X	X	X
Braddock Hospital (WMHS)		X	X (Mem)	X	X	X	X
Calvert Memorial Hospital		X	X	X	X	X	X
Carroll Hospital			X	X	X	X	X
Chester River Hospital			X	X	X	X	X
Civista Med Ctr			X	X	X	X	X
Doctors Community Hospital			X	X			
Dorchester General Hospital		X	X	X	X	X	X
Fort Washington Med Ctr			X	X	X	X	X
Franklin Square Hospital		X	X (part)	X		X	
Frederick Memorial Hospital		X	X	X		X	X
Garrett County Memorial		X	X	X		X	X
Good Samaritan Hospital		X	X	X	X	X	X
Greater Baltimore Med Ctr	X		X	X	X	X	X
Harbor Hospital		X	X	X	X	X	X
Harford Memorial Hospital			X	X		X	X
Holy Cross Hospital		X	X		X	X	X

	07/22 Meeting	09/22 Call	Baseline Data	Pledge Rec'd	Database Training	Website reg	10/09 Data
Howard County General			X	X	X	X	X
Johns Hopkins Bayview		X	X	X	X	X	X
Johns Hopkins Hospital	X	X	X	X	X	X	X
Kernan Hospital		X	X	X	X	X	X
Laurel Regional Hospital	X					X	
Maryland General Hospital			X	X		X	X
Memorial Hospital of Easton		X	X	X		X	X
Mercy Medical Center			X	X		X	
Montgomery General Hospital			X	X	X	X	X
National Institutes of Health			X		X	X	
Northwest Hospital	X	X	X	X	X	X	X
Peninsula Regional Med Ctr			X	X		X	X
Prince George's Hospital	X					X	
Shady Grove Adventist			X	X	X	X	
Sinai Hospital of Baltimore	X	X	X	X	X	X	X
Southern Maryland Hospital		X	X	X	X	X	X
St. Agnes Hospital	X	X	X	X	X	X	X
St. Joseph Med Ctr			X	X			
St. Mary's Hospital							
Suburban Hospital	X		X	X	X	X	X
Union Hospital			X	X		X	X
Union Memorial Hospital	X	X	X	X		X	X
University of MD Med Ctr	X	X	X	X	X	X	X
Upper Chesapeake Med Ctr			X	X	X	X	
VA Maryland Health Care	X		X	X		X	
Washington Adventist Hospital			X	X	X	X	