Maryland Health Quality and Cost Council

Report to the Governor and General Assembly

January 2011

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

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Maryland Health Quality & Cost Council
2010 Report

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I. Executive Summary

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. Over the past three years, the Council has implemented numerous initiatives that are saving lives, improving quality and reducing health care costs.

Maryland is home to a number of world class medical resources, including its renowned hospitals, medical and public health teaching institutions and superbly trained health professionals. We have made substantial investments in our growing innovation economy and have tremendous assets in our life sciences, biotechnology and other health-related industries. The Health Quality and Cost Council is working to harness these strengths and make Maryland one of the healthiest states in the nation.

To improve the health of all Marylanders, the O'Malley-Brown Administration has established the Council, the Maryland Health Care Reform Coordinating Council and established four strategic health goals, End Childhood Hunger by 2015, Establish Best in the Nation Statewide Health Information Exchange and Electronic Health Records Adoption by 2012, Reduce Infant Mortality by 10% by 2012, and Expand Access to Substance Abuse Services by 25% by 2012. These actions recognize that expanding access to quality care and reducing the incidence of chronic disease is necessary to contain health care costs and strengthen Maryland's economy.

During the past year, the Council's workgroups have made significant progress in implementing key strategies to improve health care in Maryland. In addition, each workgroup has been charged with incorporating strategies to address health disparities into every initiative.

Wellness and Prevention. The Wellness and Prevention workgroup made substantial progress in fulfilling its mission of developing actionable wellness and prevention strategies to achieve the goal of a *Healthiest Maryland*. Healthiest Maryland is a grass tops social marketing campaign that encourages leaders in the business, community and school sectors to embrace a culture of wellness. In May, the first phase of the Healthiest Maryland campaign, "Healthiest Maryland Businesses" was launched in Baltimore. Since the launch, a total of 103 businesses that employ more than 175,000 Marylanders have joined the program, greatly exceeding the initial goal of 75 businesses. Looking forward, it is projected that close to 125 business will be participating by early 2011. In mid-2011 staff will conduct and disseminate evaluation results. The Wellness and Prevention workgroup plans to launch the second phase of the Healthiest Maryland campaign, Healthiest Maryland Communities by December 2011.

Evidence-based Medicine. The Evidence-based Medicine Workgroup is charged with the widespread implementation of a discrete set of practices that have been shown to improve healthcare quality and decreases cost and can be instituted on a large scale relatively quickly. Initiatives to date include the Maryland Hospital Hand Hygiene Collaborative, the Statewide

Reduction of Blood Wastage Reduction Collaborative, Maryland Regulated Medical Waste Collaborative and the Telemedicine Task Force.

In 2009 the Council endorsed a statewide hand hygiene campaign that aimed to significantly reduce the number of healthcare-associated infections (HAI) in Maryland. The Council believed that a coordinated, statewide effort was the most effective approach to reducing infections. Currently, 31 of Maryland's 46 hospitals are participating in the campaign. In 2011 the Collaborative will go through a robust evaluation and will also consider adding new hospital members and the possible expansion to non-hospital settings such as nursing homes, dialysis centers or ambulatory surgery centers.

The second initiative was the Statewide Reduction of Blood Wastage Collaborative. The initiative was implemented to reduce hospital blood wastage, ensure that ample blood supplies are available and curb the expenses associated with wasted blood products. All 44 Maryland hospital blood banks voluntarily participated in this Collaborative, which over the first ten months of the initiative saved 751 combined units and $269,860. The Collaborative developed a "Craig's List" (now formally called the Inventory Visibility System) on which hospitals can list short-dated products so that other institutions can use them in emergent situations. The system was launched statewide in December and has received national attention due to the immense life-saving potential.

The final two workgroup initiatives are still under development. One is focused on the creation of the Maryland Regulated Medical Waste Collaborative, which will be modeled after the Blood Wastage Collaborative and will launch in January of 2011. The second initiative will seek to coordinate and develop a statewide telemedicine system. The Telemedicine Task Force presented the Council with its findings and leaders at the Maryland Institute for Emergency Medical Services Systems and the Maryland Health Care Commission will develop a comprehensive set of recommendations to be submitted to Council and Governor by January 2012.

Patient Centered Medical Home. The Patient Centered Medical Home Workgroup is tasked with developing recommendations to strengthen primary care and promote the adoption of the medical home model, which is vital to improving patient care, achieving good outcomes and lowering costs. In 2010, the workgroup worked with the Administration to pass legislation that establishes a multi-payer Patient Centered Medical Home (PCMH) program that seeks to improve primary care delivery through incentives to practitioners to better coordinate care and manage chronic disease. This model has also been cited as a strategy to make primary care more attractive as a medical specialty. The pilot program will launch in January 2011 with sixty practices, covering over 200,000 Marylanders.

In light of these accomplishments, the Council will continue to set priorities and propose recommendations to sustain successful initiatives while championing new areas of focus aimed at addressing disparities, broadening the scope of projects into additional healthcare settings and leveraging the many opportunities provided under federal health reform.

II. Introduction and Background

COUNCIL'S ESTABLISHMENT AND PURPOSE

In October 2007, Governor Martin O'Malley established by executive order 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.

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.

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. Its health care system serves its diverse and relatively affluent population within Maryland, as well as patients from other states and across the world. Despite our may assets and advances, by most objective measures Maryland continues to be rated as average in terms of the quality of its health care system, the health of its population and the cost of its care.

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, placed Maryland in the middle relative to its peers based on a weighted ranking of these elements.[1] 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. In the past year, immunization coverage decreased from 92.4 percent to 82.6 percent of children ages 19 to 35 months receiving complete immunizations. In the past five years, the prevalence of smoking decreased from 20.1 percent to 14.9 percent of the population. In the past ten years, the rate of cancer deaths decreased from 220.4 to 198.5 deaths per 100,000 population. Since 1990, the prevalence of obesity increased from 12.0 percent to 26.6 percent of the population. The report notes health disparities in the State where obesity is more prevalent among non-Hispanic blacks at 35.2 percent than non-Hispanic whites at 23.8 percent. The prevalence of diabetes also varies by race and ethnicity in the state; 11.4 percent of non-Hispanic blacks have diabetes compared to 7.5 percent of non-Hispanic whites. In addition, mortality rates vary in Maryland, with 994.0 deaths per 100,000 population among blacks compared to whites, who experience786.7 deaths per 100,000 population.

Lackluster results were also reported in the most recent edition of the Commonwealth Fund's State Scorecard on Health System Performance, where Maryland ranks only slightly above the middle on an aggregate indicator of health system performance.[2] 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 2009[3] similarly rated Maryland's health care quality as average among the nation. Chronic and preventative care measures remained in the average category from 2008 to 2009.

[1] United Health Foundation. (2009). America's Health Rankings: A Call to Action for Individuals & Their Communities, 2009 Edition. Retrieved October 17, 2010, from United Health Foundation Website: http://www.americashealthrankings.org/yearcompare/2008/2009/MD.aspx

[2] 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.

[3] Agency for Healthcare Quality and Research and Quality. (2009). National Healthcare Quality Report, 2009 Retrieved October 17, 2010, from AHRQ Website:http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf

Preventative care sub-measures did improve from 2008 to 2009 with 44 percent of the indicators outperforming the national average in 2009, comparing to only 20 percent in 2008. Acute care measures were rated as weak, falling from the average category in 2008.[4] While looking at health care quality by different settings, home health care in Maryland rose to the best quality quintile from the second best quintile from 2008 to 2009 among all states. Ambulatory and hospital care declined somewhat but remained in the average category. Nursing home care also remains in the average category, showing little change. Additionally, maternal and child health care worsened from the average to the weak category. [5]

Adverse events in health care settings, such as healthcare-associated infections put patient safety at risk and generate unnecessary and expensive costs to the system. 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 addition to the substantial human suffering exacted by HAIs the financial burden attributable to these infections is staggering. It is estimated that HAIs incur an estimated $28 to $33 billion in excess healthcare costs each year.[6] According to the AHRQ, there are 8.73 cases for selected infections due to medical care per 1,000 discharges in Maryland, slightly above the national average of 8.6 cases in 2009.[7] Central Line-Associated Blood Stream Infections (CLABSIs) are a leading cause of healthcare-associated infections in the acute care hospital setting. The Centers for Disease Control in May released a report detailing state-specific and national CLABSI data using the standardized infection ratio (SIR) calculation. Maryland reported CLABSI data from 45 acute care facilities and had the highest SIR of the 17 states mandated to report such data. The Maryland Health Care Commission in October added hospital-specific CLABSI data to its Hospital Performance Evaluation Guide[8] and will begin regularly reporting on this outcome measure. On December 6, 2010, the Maryland Hospital Association kicked off the *On The CUSP: Stop BSI* patient safety initiative, of which 89 percent of Maryland acute general hospitals are participating.[9]

Preventable hospitalizations in Maryland are slightly above the national average, at 72.6 per 1,000 Medicare enrollees in 2009, an improvement from 75.1 per 1000 Medicare enrollees in

[4] ibid.
[5] ibid.
[6] Scott Rd. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, 2009. Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, February 2009.
[7] Agency for Healthcare Quality and Research and Quality. (2009). National Healthcare Quality Report, 2009 Retrieved October 17, 2010, from AHRQ Website:http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf
[8] The Hospital Performance Evaluation Guide is a web-based tool that provides information to the public on how hospitals care for patients and how patients rate the care they received during their hospital stay. http://mhcc.maryland.gov/consumerinfo/hospitalguide/
[9] The Agency for Healthcare Research and Quality is funding the national implementation of a patient safety initiative modeled after the success of Michigan's Keystone ICU Project in dramatically reducing CLABSIs. The project involves two components: the Comprehensive Unit-based Safety Program (CUSP) to improve safety culture, and the use of evidence-based CLASBI elimination tools.

2008, moving from below national average to above national average.[10] The Health Services Cost Review Commission estimated $700 million in charges for potentially preventable readmissions within 30 days in 2009. They also reported 7.9% hospital-based preventable complications out of the State's inpatient cases, amounting to about $580 million in potentially preventable hospital payments in FY 2010. [11]

With these disparate quality indicators in mind, the Council has continued to work on several priorities aimed at improving health care quality and reducing health care costs in the State. The Wellness and Prevention Workgroup has championed the "Healthiest Maryland" campaign to promote healthy eating and prevention of tobacco use to address prominent risk factors for chronic diseases. Healthcare-Associated Infections are the central focus of the Evidence-based Medicine Workgroup. Rigorous data reporting and auditing, implementation of evidence-based interventions with proven success will further reduce infection rates. Access to health care will continued to be monitored and improved by the Patient-centered Medical Home Workgroup. In light of these efforts, the Council will continue to set priorities and propose recommendations to sustain successful initiatives while championing new areas of focus aimed at addressing disparities, broadening the scope of projects into additional healthcare settings and leveraging the many opportunities provided under federal health reform.

HEALTH DISPARITIES

The Institute of Medicine (IOM) defines a *health disparity* as a difference in the burden of illness, injury, disability, or mortality experienced between one population group and another. A *healthcare disparity* is defined as racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention." [12] The prevalence and impact of health disparities continues to be significant both nationally and in Maryland. The 2008 National Healthcare Disparities Report from the Agency for Healthcare Research and Quality states that nationally 60 percent of disparities in quality of care measures are either not improving or actually getting worse over time. In Maryland, racial and ethnic minority disparities exist for 10 of the 14 leading causes of death. Areas of significant disparity include cardiovascular disease, cancer, diabetes, HIV/AIDS, kidney disease, asthma, coverage by health insurance, ability to afford health care, and utilization of mental health services. As the Council continues to move forward with initiatives to improve quality and reduce health care costs it is essential that we address disparities that plague far too many of our minority residents.

The Department of Health and Mental Hygiene's Office of Minority Health and Health Disparities (OMHHC) in April expanded its focus from just the areas of cancer and tobacco-related illnesses to minority health disparities in all DHMH programs. OMHHD has done an

[10] United Health Foundation. (2009). America's Health Rankings: A Call to Action for Individuals & Their Communities, 2009 Edition. Retrieved October 17, 2010, from United Health Foundation Website: http://www.americashealthrankings.org/yearcompare/2008/2009/MD.aspx.
[11] The Maryland Health Services Cost Review Commission (2010). Health Services Cost Review Commission Report to the Governor for FY 2010.
[12] Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002).

extensive literature and historical overview[13] of health disparities in the State that will be a resource to the Council as we refine ongoing initiatives and will guide future projects.

OMHHD presented to the Council at its June meeting on an overview of disparities data in the State. The presentation focused on the need for broad-based quality improvement initiatives that are delivered to all segments of the population equally. Suggested targets for action to reach minority populations include public insurance programs, safety net providers, the correctional system, community centers, local public services and community-based organizations. Disparity themes were then presented for each workgroup initiative, including suggestions for targeted outreach, representation, cultural/linguistic appropriateness, data collection and minority and disparity benchmarks for evaluation. Moving forward the Council agreed that each workgroup should consider recommendations to integrate strategies to address disparities in approved initiatives.

Further emphasis on this important issue resulted from the signing of the Affordable Care Act, including promotion of the Office of Minority Health, grant funding that prioritizes underserved communities and public health initiatives aimed at addressing diseases that disproportionately impact minorities. The Affordable Care Act also includes specific workforce provisions to improve the diversity in the health care workforce while addressing known shortages. The Council will work to advance the many opportunities provided under the Affordable Care Act in our coordinated effort to eliminate minority health disparities in Maryland.

COORDINATION OF ACTIVITY RELATED TO REFORM IMPLEMENTATION

The Patient Protection and Affordable Care Act was signed into law by President Obama on March 23, 2010. The next day, Maryland Governor Martin O'Malley signed Executive Order 01.01.02010.07, creating the Health Care Reform Coordinating Council (HCRCC) to coordinate Maryland's response to Affordable Care Act. The objective of the Executive Order and the HCRCC is to ensure that the state implements federal health care reform thoughtfully and thoroughly, with careful deliberation and collaboration across agencies and all branches of government, and with meaningful participation of the health care community and other private sector stakeholders.

The Executive Order created the HCRCC as the primary body in Maryland charged with coordinating state government activity in implementing Affordable Care Act. The HCRCC is directed to identify and present a series of recommendations on the issues and decisions that are critical to the successful implementation of health care reform in Maryland. To fulfill this mandate, the HCRCC must submit both this interim report and a final report by January 1, 2011. In its Interim Report, presented on July 26, 2010, the HCRCC identified the need to focus on "bending the cost curve" and established the Health Care Delivery System Workgroup.

[13] See for example Maryland Plan to Eliminate Minority Health Disparities, Plan of Action 2010 – 2014 (March 2010). Available at http://www.dhmh.state.md.us/hd/pdf/2010/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf and Maryland Chartbook of Minority Health and Minority Health Disparities Data, 2nd Edition (December 2009). Available: http://www.dhmh.state.md.us/hd/pdf/2010/Chartbook_2nd_Ed_Final_2010_04_28.pdf

The success of health care reform will depend in large measure on the degree to which the delivery system is transformed. The Affordable Care Act offers states tools to achieve this goal: providing opportunities for pilots, demonstration projects, and other mechanisms to test and evaluate delivery system changes designed to improve quality and rein in costs.

The HCRCC acknowledged in its Interim Report that Maryland has already initiated several such efforts with the creation of the Maryland Health Quality and Cost Council, among others. In addition, the Reform Council's delivery system workgroup, which met from early August through the end of October, included presentations on the Patient Centered Medical Home model and Healthiest Maryland, as well as discussions around comparative effectiveness research and ways in which Maryland could benefit from a coordinated dissemination effort.

The goals of the HCRCC closely align with those of the Quality and Cost Council, which can be the vehicle by which to deal specific of quality improvement and cost containment initiatives. Further, the Affordable Care Act includes grant opportunities for many of the initiatives the Council has supported and Staff will continue to work to capitalize on those opportunities moving forward.

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.[14] 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 by developing 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.[15] As this report outlines, these exercises served 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

[14] Available: http://www.governor.maryland.gov/executiveorders/01.01.07.24eo.pdf
[15] 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. Initially, 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; and
- Addressing proposed legislation and regulatory changes necessary to accomplish proposed strategies.

During the past year, the workgroups of the Cost and Quality Council made significant progress in implementing their key strategies. In addition, midway through the year, each workgroup was charged with considering ways each initiative might be designed to ameliorate health disparities and to evaluate results accordingly. Workgroups were challenged to present evaluation plans and timelines with key milestones to the Council for approval.

WELLNESS AND PREVENTION WORKGROUP

Charge

The Wellness and Prevention workgroup developed actionable wellness and prevention strategies that fulfill the Maryland Health Quality and Cost Council's efforts to advance wellness, prevention, and chronic care management toward the overarching goal of a healthier State. The aim is to make healthier choices easier, such as eating healthier, being physically active, and adhering to recommended preventive screenings and treatment.

Recommendation 1: Implement Healthiest Maryland throughout the State.

Healthiest Maryland is the leading strategy designed to improve wellness and prevention. Healthiest Maryland is a grasstops social marketing campaign that engages 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 and practices that promote and facilitate healthy eating and physical activity.

Healthiest Maryland Businesses

Healthiest Maryland Businesses is the cornerstone of the Healthiest Maryland initiative. It was prioritized because of the overwhelming evidence supporting worksite wellness, the Health Quality and Cost Council members' experience and success in this arena, and partnerships with the Greater Baltimore Committee, Mid-Atlantic Business Group on Health, and the Partnership for Prevention. Furthermore, business leaders serve in school and community leadership positions.

Making the Case for Worksite Wellness. Partnership for Prevention and the US Chamber of Commerce have launched a national *Leading by Example*, CEO-to-CEO initiative that Healthiest Maryland Businesses is modeled after.[16] According to a literature review 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

[16] 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/

- Average 30 percent reduction in workers' compensation and disability management claims costs
- Average $5.93-to-$1 savings-to-cost ratio

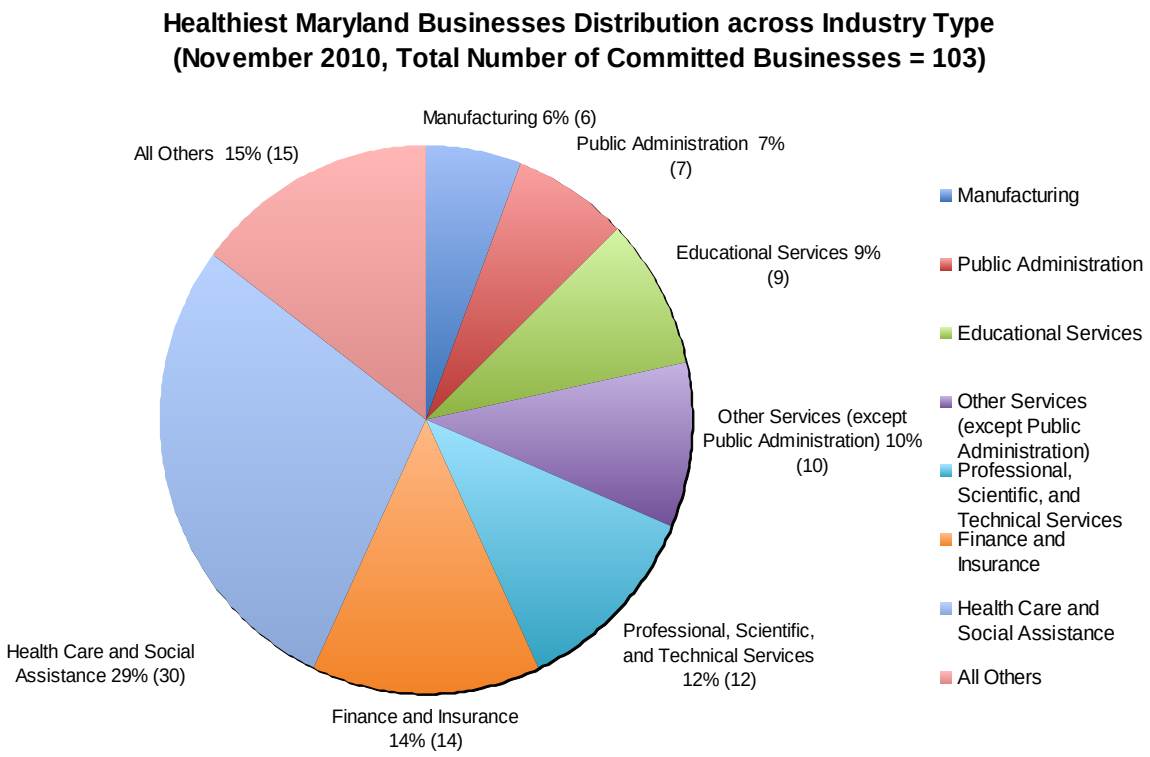
Elements of Healthiest Maryland. The Healthiest Maryland campaign consists of three prongs—recruitment of businesses, referral to evidence-based resources, and recognition for participants. Recruitment has focused on statewide launching media events completed in coordination with the Lt. Governor's office, the Department, and Health Quality and Cost Council members. Additionally, there is a Healthiest Maryland Businesses marketing plan (developed by greiBO, Inc.) that focuses on messaging, partnership marketing, media and recognition, and online social media. Recruitment efforts also have been assisted greatly by community partners such as local health departments, Greater Baltimore Committee, Mid-Atlantic Business Group on Health, and Partnership for Prevention. A complete list of participating businesses, supporting organizations, and ambassadors is located in Appendix B.

The businesses also have received education and technical assistance via online tools and ambassadors, which are businesses who administer exemplary worksite wellness programs. Many partners, such as local and regional chronic disease coalitions, nonprofit health organizations, health insurance providers, hospitals, local Chambers of Commerce, the Greater Baltimore Committee, and the Mid-Atlantic Business Group on Health offer a venue for convening employers to share best and promising practices. They also provide a venue for reaching out to businesses in industries that employ disparate populations.

By committing to join Healthiest Maryland Businesses, each member business is publicly recognized by having their name listed on the Healthiest Maryland Businesses Registry on the Healthiest Maryland website. The participating businesses will also have access to the Healthiest Maryland logo. Further recognition events will be determined based on resource availability.

Healthiest Maryland Businesses Update. The goal of Healthiest Maryland Businesses was to recruit 75 businesses from rural, suburban and urban communities throughout Maryland and reach 50,000 Maryland workers. During the first quarter's efforts, 85 businesses were recruited, and these businesses employ more than 50,000 Marylanders. The second quarter brought further success with 103 businesses committed as of November 2010. Well attended launches were held in Baltimore, Salisbury, Rockville, and Cumberland, Maryland. Looking forward, it is projected that close to 125 business will be participating during the third quarter.

Among the current participating Healthiest Maryland businesses, the industry types most represented are health care and social assistance (28%), finance and insurance (14%), professional/scientific/technical services (12%), and other services- except public administration (10%) (See Figure 1).



Addressing Disparities. Using the 2008 Maryland data from the U.S. Equal Employment Opportunity Commission, the occupation distribution was analyzed by industry and race. In Maryland, there are 957,114 full-time employees in the private sector, and 120,605 full-time employees in the public sector. When considering the total number of Black or African American[17] employees statewide (private and public), the majority are employed in the private sector (85.9%) compared to the public (14.1%). Black or African American employees in Maryland have a higher representation in health care and social assistance (28%), retail trade (18%), and administrative and support/waste management/remediation services (10%). These three industries reach 156,187 Black or African American Marylanders, or 48.2% of the total Black or African American workforce. These industries are well represented within Healthiest Maryland Businesses.

Evaluating Healthiest Maryland. In order to assist with data collection and evaluation, the Maryland Institute for Policy Analysis and Research (MIPAR) at the University of Maryland Baltimore County has been contracted to lead an external evaluation of the Healthiest Maryland Businesses campaign and an assessment of barriers and facilitators of workplace wellness in Maryland. Their evaluation will include both qualitative and quantitative assessments, including information from organizational leadership, employees, and existing surveillance data such as the Maryland BRFSS. In year one, the evaluation will provide baseline data on worksite

[17] Data are limited to comparisons of the Black or African American population to the White population because either the data have small numbers for other minority populations, generating statistically unstable estimates or the data have large numbers of persons who are missing racial or ethnic information.

wellness programs and their effects. Year two of the evaluation will focus on how Healthiest Maryland has influenced worksite programs. All of the evaluation components will be repeated in the summer and fall of 2011. See Appendix D for a detailed summary of the Evaluation Plan.

Healthiest Maryland Communities

Healthiest Maryland's next foray is Healthiest Maryland Communities. Continuing the grasstops social marketing approach, Healthiest Maryland Communities empowers pillars within the community to make policy and environmental changes that make the healthiest choice the easiest choice. Three agents of change have been identified: respected community leaders, small business owners, and local government.

Respected Community Leaders. The University of Maryland, Baltimore (UMB) educates a plurality of the state's health, social work professionals, and attorneys. These professionals are often respected leaders within a community. Additionally, UMB has made a commitment to improving the health status of all Maryland residents, including a priority to address prevention and treatment of childhood obesity. As an element of Healthiest Maryland, UMB and the Council are creating an inter-professional development program within the President's Clinic related to obesity prevention, which translates national recommendations—Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity into clinical practice.

Small Business Owners. Small business owners can be a foundation within the community, and food outlets are often a focal point. Unfortunately, opportunities to promote good health may be missed within these venues. There are areas of Maryland that are considered food deserts because they lack ready access to healthy foods. As both a community agent of change and a necessary outlet to improve nutrition, small grocers and convenience store owners will be engaged with Healthiest Maryland Communities.

The Healthy Stores projects aim to improve health and prevent obesity and disease in low-income communities through culturally appropriate store-based interventions that increase the supply of healthy foods and promote their purchase. Healthiest Maryland Communities will work with Johns Hopkins University to assess the feasibility of the Healthy Stores effort within one low-income rural Maryland County. Charles County was selected because of its high obesity rates, strong health department to sustain the program, and a low prevalence of WIC vendors, stores with greater than four employees, and farmers' markets.

Local Government. Engaging local government is a critical agent of change in local communities. Through embedding the prioritization of wellness policies within local governmental agencies, significant health promotion can occur. Healthiest Maryland Communities will seek to infiltrate multiple public programs to ensure that their mission aligns with Healthiest Maryland.

2010 Accomplishments

- Launched Healthiest Maryland Business, recruiting more than 100 businesses;

- Achieved diversity in the participating businesses by region, industry type, racial composition, and size;
- Partnered with nationally recognized and accredited worksite wellness programs to make resources available to Maryland businesses;
- Elevated the awareness of Maryland businesses that already have achieved monumental success in improving the health of their workforce;
- Established the framework for an evaluation that will assess the long-term implications, including ROI for businesses; and
- Developed the foundation to launch Healthiest Maryland Communities.

2011 Milestones

- Maintain the momentum of Healthiest Maryland Businesses through continued recruitment efforts, referral resources and recognition opportunities by December 2011;
- Disseminate preliminary evaluation results to Council members by June 2011; and
- Launch Healthiest Maryland Communities by December 2011.

Recommendation 2: Champion the recommendations of promising public and private sector initiatives, including the Maryland Childhood Obesity Report.

The Wellness and Prevention Workgroup identified a need to focus on the prevention of diabetes and obesity, but also recognized the work of the Childhood Obesity Committee. The Committee submitted a legislative report in December 2009, which contained 12 priorities related to policy and environmental change, health care, public awareness, and infrastructure. To act on these recommendations, workgroup developed Healthiest Maryland. Thus, this recommendation has been met through the implementation of Healthiest Maryland Businesses and Healthiest Maryland Communities. See also Appendix B for select wellness and prevention provisions provided for under the Affordable Care Act that can further support the promising initiatives underway in the State.

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EVIDENCE-BASED MEDICINE WORKGROUP

Charge

The Evidence-based Medicine Workgroup is charged with prioritizing the widespread implementation of a discrete set of practices (so far mainly in hospital-based settings) that have been shown to improve healthcare quality, decrease cost and could be instituted on a large scale relatively quickly. The Council initially 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.

Overview

The workgroup routinely holds two conference calls between quarterly Council meetings—occasionally a third call is held. All calls are publicized on the Quality Council website so the public may join in. The format of these calls is to first receive an update on ongoing collaboratives/projects and make any interventions necessary with them, then to consider topics for and timeliness of rolling in new projects. Two large collaborative projects, Hand Hygiene and Blood Wastage Prevention, were kicked off in fall of 2009. (See individual project reports for details.) Prior to the December, 2009, meeting the workgroup decided they wished to propose that we continue to sponsor new evidence-based "quick turnaround" projects.

The group put out a "call for ideas" letter to hospital CEOs in January of 2010, and met face-to-face with an MHA committee in April to get ideas for future projects. Several areas were proposed that will be kept on a back burner for possible future activity. Projects that received serious consideration at this time included a statewide project to address central line infections, including adoption of a central line placement checklist, and a reduction of readmissions initiative. The Council decided on the first topic to request that MHA implement a central line project across hospitals quickly, and to table the readmission project because HSCRC was already undertaking a rate refinement project for Maryland that focuses on readmissions.

At the June Council meeting the workgroup proposed implementation of a telemedicine project, focused on stroke as the pilot specialty area for consideration, and a red bag (medical waste) reduction project. These groups began to meet over the summer.

The workgroup has discontinued use of their previous alias, "Low Hanging Fruit Group," in recognition of just how complex and labor intensive the "quick turnaround" project can be.

Evidence-based Medicine Strategies

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

In 2009 the Council endorsed a statewide hand hygiene campaign that aimed to achieve immense life and cost-saving potential represented by a significant reduction in the number of healthcare-associated infections (HAI). 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 standards by which to measure improvement across facilities.

The Council agreed that 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 pre-existing patchwork of individual, well-intended, but divergent facility efforts.

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 purpose 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 employs observers whose task is unknown to the staff being observed and 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. The Collaborative goal is for all Collaborative participants to achieve a hand hygiene compliance rate of at least 90 percent for all unit/participants.

In 2010 the Collaborative held three face-to-face statewide meetings for hospital infection control professionals and others, two webinars focused on the methodology and data reporting, two statewide conference calls, three letters to hospital CEOs, and one call to hospital CEOs. The evidence-based workgroup has held nine conference calls at which collaborative progress was reviewed and recommendations made for program direction.[18]

Data collection began across all participating hospitals in February 2010. As the project team tracked hand hygiene compliance data as well as process measures it became clear that a number of facilities were struggling to consistently implement the project requirements. Challenges cited by the hospitals included lack of new resources, confusion about the definition of unknown observers, and about the number of units required. Hospitals had various hand-hygiene programs in place prior to the collaborative, and were unclear about changing to the standard program or unable to support the additional staff time needed to change to the standard program.

Staff began a series of activities to address the data integrity concerns and to clear up remaining confusion among participating hospitals. Beginning with a June 15 face-to-face statewide meeting, hospitals were asked to reconfirm their ability to carry out the project requirements and the standard methodology. Of the original 42 hospitals, 31 have "recommitted" to the collaborative, so that observations beginning September 1, 2010 will be comparable. The 11 facilities unable to meet the Collaborative requirements will continue to have access to

[18] All Collaborative material can be accessed at:
http://www.marylandpatientsafety.org/html/collaboratives/hand_hygiene/index.asp

information from the collaborative; however, those teams will not have access to submit their data, receive reports or receive technical assistance until they are able to meet the project requirements. Notably, among the 31 hospitals, the total number of participating units as of September 2010 (including Med-Surgical, Pediatrics, and ICU) is 373. Of these, 353 are acute care units ad 20 are specialty units. This represents 6,842 beds, or 77 percent of all Maryland medical/surgical beds.

Early on in the project, hand hygiene compliance rates for the 14 hospitals that were performing the standard protocol on the majority (80%) of their units averaged 71 percent for the quarter ending in July, 2010. After the intervention and recommitment of hospitals, the average compliance rate for October was 72 percent.

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 – this one on hand hygiene and one focused on multi-drug resistant Acinetobacter. In addition, the hand hygiene collaborative relies on a significant amount of in-kind support from the Johns Hopkins Medicine's Center for Innovation in Quality Patient Care.

The Maryland Patient Safety Center was able to obtain an additional funding source through the Health Services Cost Review Commission so that the project is supported until June 30, 2011. At that time we will have 10 months of data to show impact of the program. It is anticipated that an evaluation will be performed and possibly published about the experience as the first statewide hand hygiene initiative with standardized methodology and data tracking. Future plans include examination of Maryland healthcare acquired infection data that coincide with the time period for the hand hygiene collaborative. See Appendix E for a complete list of HAI data collection and reporting activity in the State.

Activities Continuing into 2011

Monthly technical assistance calls to individual hospitals are continuing. Current monthly calls focus on issues related to hospital leadership support, champions, promotion of hand hygiene, presentation of compliance data, rewards/recognition for compliance improvement, use of unknown observers, and education for families. One site visit to a western Maryland hospital was completed in September, and others may follow. A Webex was scheduled for November 30 on the topic of process measure reporting. The future Learning Session is scheduled for March 9, 2011.

In the next few months the collaborative plans to begin use of a compliance report card for hospitals. Validation of hospital hand hygiene compliance reports has been discussed, but no firm plans made as yet. The collaborative will consider adding new hospital members, and possible expansion to non-acute settings in 2011.

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 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. It was agreed that blood is a precious commodity and that the variability of the supply directly affects 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.

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.[19] 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 44 hospital blood banks were participating in the Collaborative, for a participation rate of 100 percent. The Blood Wastage Workgroup assisted in the development of a website in which Collaborative participants are 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. 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.

Twelve months of data were collected by all participants to establish current baseline wastage. Wastage rate for platelets was 8 percent at baseline and 5 percent for plasma. The collaborative members set a goal of 1 percent reduction in wastage by August 31, 2010, for the two products.

The collaborative was on a trend line to save more than the 1 percent goal before the February 2010 blizzards that reversed a sizable part of the previous aggregate saved units due to transportation difficulties and increased wastage. However, the collaborative still reduced wastage by 0.95 percent for platelets and 0.30 percent for plasma over the first ten months, and saved a total of 751 combined units for a savings of $269,860. Increased availability of a scarce resource is a program benefit that is unquantifiable. Final numbers after additional months of practice may get closer to or exceed the 1 percent goal.

The collaborative over the last year has held 3 face-to-face meetings. The Blood Wastage Workgroup also coordinates quarterly follow-up calls with all collaborative participants to discuss best practices and data submitted. At the most recent statewide call on December 8, 2010, members discussed continuing the collaborative by continuing to report blood wastage data. In addition, the members agreed to continue the focus on plasma and platelets and have

[19] 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

proposed establishing the goal to reduce the wastage rate for both products by an additional .5%.

The data base is sophisticated enough to allow hospitals to compare their own performance over time, to the aggregate, or to a group of hospitals with similar characteristics. During the start-up of the collaborative best practices were shared across hospitals and are maintained as part of the data base. Members also developed the concept of a "Craig's List", now formally called the Inventory Visibility System, on which short-dated products are listed so that other hospitals can use them. This system is being piloted as of November 22, 2010 with seven hospitals (UMMS, St. Agnes, Bayview, Howard County, Suburban, Sinai, Northwest, and Bon Secours) before going statewide on December 8, 2010 and has already received attention from the National Red Cross President of Biomedical Sciences.

Recommendation 3: Regulated Medical Waste

The Council authorized implementation of a project to reduce regulated medical waste in hospitals at their June, 2010, meeting. The planning meeting was held August 25 with representatives from the John Hopkins Center for Innovation, Johns Hopkins Hospital, Hospitals for a Healthy Environment (H2E), the Department of the Environment, and DHMH.

The planning group discussed the scope of the project and determined it should be limited to medical waste rather than the entire hospital trash stream. Membership for the taskforce was proposed, with representatives from community hospitals, state hospitals, and the Maryland Hospital Association suggested.

The first meeting of the taskforce, at which the concept of a hospital survey was discussed, was held in October, 2010. The first taskforce activity will be conducting the survey of current regulated medical waste initiatives in Maryland hospitals. Survey results are currently being collected, and the taskforce will reconvene when results are available. The survey focuses on what individual hospitals are currently doing in this area, how they track their projects, how they define activities, and which metrics are being used. The next step will be to design a standardized tool to capture a first year of baseline data in the hospitals. The data collection tool will be modeled on the successful blood wastage data collection tool designed by the Center for Innovation. Kick-off for the measurement of the baseline year is expected in January, 2011. The taskforce website is expected to be up in late January, 2011.

Recommendation 4: Statewide Telemedicine Network

The telemedicine taskforce is co-chaired by Drs. Eric Aldrich and Barney Stern, neurologists from Johns Hopkins and University of Maryland, respectively. Members include representatives from American Heart and Stroke Association, Maryland Hospital Association, Maryland Chapter of American College of Emergency Physicians, Board of Physicians, Board of Nursing, a Wellness Center, MedStar, Washington County Hospital, Sinai Hospital, MHCC, HSCRC, Maryland Institute for Emergency Medical Services Systems (MIEMSS) and DHMH.

The group met for the first time in July, 2010 after the Quality Council voted to request a fleshed out report/business plan on telemedicine for consideration at the September 24, 2010, meeting. A second meeting in August was held for the purpose of writing an outline for the report, with

each member submitting a few pages of information for the final report. The third meeting, at which members commented and revised the draft final report was held on September 15, 2010.

Draft recommendations include creation of a statewide telemedicine system aimed at eventually alleviating ED and other hospital department problems with limited availability of specialty consultation, but focusing first on stroke as a pilot. The system would also be used in case of emergencies, for example, due to natural disasters or bioterrorism.

The draft report[20] recommends the state develop detailed standards and release a request for applications (RFA) to IT companies. Other jurisdictions should be allowed to participate if possible. Initial funding should be provided, perhaps in the form of grants to hospitals. Reimbursement of the physician component of the service may need to be mandated via legislation. Telemedicine system hospitals will be required to participate in the Maryland Health Information Exchange.

The Council considered the draft report recommendations and future direction for this group at the September 24, 2010, meeting, and suggested they continue to flesh out a proposal for a telemedicine system in Maryland. The Task Force met in October and adopted a new direction where two state agencies, MIEMSS and MHCC, together direct a telemedicine initiative that is broader than stroke, to address an interoperable approach to the many disease categories of concern in Maryland. MIEMSS is a clear leader with their jurisdiction over emergency care and the MHCC provides oversight for the State's HIT initiative in addition to serving as a regulator to state hospitals. The current Telemedicine Taskforce focusing on stroke will be instrumental in selecting use cases (stroke, trauma, perinatal, ICU, dermatology, others) to be studied for the definition of elements critical for Maryland's comprehensive telemedicine system, and suggesting individuals with particular areas of expertise to define the elements and standards for the telemedicine system. In addition, Telemedicine Taskforce members were invited to join any of the advisory group being developed to replace the Telemedicine Taskforce:

1) **Clinical Advisory Group**: to include physicians with particular disease area expertise, Chief Medical Officers, MedChi, and MHA. This group will be chaired by Dr. Bob Bass, Executive Director, MIEMSS.
2) **Technical Solutions and Standards Advisory Group**: to include hospital CIOs, Maryland Department of Information Technology, CRISP and Health Information Exchange representatives. This group will be chaired by David Sharp, Ph.D., Director, Center for Information Technology, MHCC.
3) **Financial and Business Model Advisory Group**: The group will have meetings with payers, most likely represented by a medical director, as well as hub and spoke hospital representatives, and hospital CFOs. This group will be chaired by Dr. Rex Cowdry, Executive Director, MHCC.

It is anticipated that the Clinical Advisory Group would make their recommendations prior to the bulk of the work by the Technical Solutions/Standards Advisory Group and Financial Group.

[20] The Telemedicine Taskforce's Report to the Council is available at:
http://dhmh.maryland.gov/mhqcc/pdf/2010/Sep10/Telemedicine_Task_Force_Presentation_09242010.pdf

The work will take place primarily during spring, summer, and fall of 2011, with a quarterly update to the Quality and Cost Council and a Final Report submitted to the Governor by January of 2012.

PATIENT CENTERED MEDICAL HOME WORKGROUP

Charge

The Patient Centered Medical Home Workgroup was 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. The Workgroup worked to develop a multi-payer PCMH model that balances the triple objectives of achieving system savings, enhancing the health of the patient population, and improving primary care delivery.

The Workgroup brought together 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 Workgroup 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).

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 PCMH literature and others' experiences gained to identify best practices and approaches.	Identify the work of states; providers, carriers, 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.	Provide 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.

In 2009 the Workgroup participants formulated an action plan and pilot staff identified nine areas within that plan on which agreement was needed. The nine areas, which are shown in Table 2, allowed the Workgroup to identify important issues. 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 Workgroup and subgroups met a number of additional times to consider the issues within 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 needing 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, and private).		***X***	
Create standards for patient education program.			***X***

Note: The Purchaser and Consumer Education Subgroup meet once during the summer of 2009 and resumed meetings in the Spring of 2010.

The Workgroup was able to cover much of its agenda during 18 meetings from March through December 2009, and this continued through July 2010. As of mid-year 2010, the number of Workgroup participants had grown to more than one hundred members. During each of the meetings, members were actively engaged in the issues under discussion. The Workgroup participants were updated on the proposed legislation and the NASHP Medical Home Technical Assistance Grant activities early in 2010.

One of the most important issues that carried over to the Workgroup in 2010 was reaching consensus on a preliminary reimbursement scheme. The reimbursement framework defined in the *Joint Principles for the Patient-Centered Medical Home*[21] 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

[21] 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

desirable. Several approaches were considered, including the Prometheus[22] methodology and full capitation of care under the PCMH. The Workgroup participants agreed that a shared savings model was an intermediate approach that would establish cost savings as an important priority. Under this model, a portion of reimbursement is based on savings that the medical home can generate through enhanced care coordination provided by members of the patient's care team, which can lead to improved patient's outcomes and lower overall health care costs through reduced use of the emergency department and avoided, unplanned hospital admissions and readmissions.

This payment methodology has been tested in the Physician Group Practice Demonstration in Medicare. In Maryland's PCMH pilot, practices will be reimbursed as usual for fee-for-service ("FFS") care, and carriers will pay practices on a per patient per month ("PPPM") basis for care coordination expenses not included in their standard FFS schedules. The reimbursement methodology is summarized below:

Fixed Payments are guaranteed and adjusted by PCMH recognition level, category of carrier (commercial, Medicaid MCO, and Medicare MCO), and practice size.

- Paid prospectively: quarterly or semi-annually.
- Range of $3.00 - $6.00 PPPM for commercially insured populations.
- Total fixed payment range of $40,000 - $60,000 per full-time physician annually.

Shared savings payments could be substantial, but are not guaranteed.

- Calculated based on achieved total savings from all care (IP, Rx, Outpt, and Prof).
- Separately calculated for commercial (grouped together for all carriers), Medicaid, and Medicare (if Maryland participates in the CMS demonstration).
- Baseline for savings will be the practice's patients' total medical expenses, adjusted for inflation and plan benefit changes since the start of the Pilot.
- Paid retrospectively.

Bonus, or shared savings, payments would be derived from the savings that the carriers are able to document, with the largest percentage 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.

[22] 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

Cost

The Workgroup has categorized components of costs (Table 3). It is not feasible to estimate an absolute cost for the pilot project; however, the most important driver of costs will be the number of practices that are participating and the potential benefits of the PCMH model of care are significant to all stakeholders. The Workgroup members believe that when the costs are carefully balanced against possible gains that carriers, Medicaid, possibly Medicare, purchasers, Maryland government, and consumers will agree that the expense is worth the risk.

Table 3. 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); CMS has estimated maximum PMPM as $10.00 for Medicare patients (July 2010)	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.

The PCMH Workgroup spent considerable time developing recommendations to the Council on:

- The participants, scope, and duration of the PCMH Pilot program;
- The quality measurement, payment, and evaluation approach; and
- Options for integrating external and community resources into the PCMH pilot.

Update

Task - 1 Pass Legislation/ Finalize Legal Approach

House Bill 929 and Senate Bill 855 was introduced with significant legislative sponsorship and passed unanimously in the House of Delegates and the Senate. The bill was signed into law by Governor Martin O'Malley on April 13, 2010, with an effective date of July 1, 2010.

The Administration bill establishes a PCMH program consisting of a multi-carrier pilot and single carrier initiatives under the authority of the MHCC and authorizes MHCC to approve a single carrier (private or public carrier) PCMH program. The bill requires all large private payers to participate in the multi-payer pilot and directs the Maryland Medical Assistance Program (Medicaid) to participate in the multi-carrier pilot to the extent permitted by federal/State law and the State budget. The bill waives prohibitions on cost-based incentives and information sharing in the Insurance Article when used in a PCMH initiative approved by the MHCC. Specifically, a PCMH program may use cost-based incentives in addition to quality-based measures and a carrier may share information with practices in the PCMH if the patient consents to this when joining the PCMH. Finally, the bill establishes a state action exemption under anti-trust law that will permit payers and providers to collaborate in the development of payment and performance measurement in the PCMH.

Task 2 Develop Payment Methodology and Quality Measures

Planning for the payment and performance measures is near completion. The MHCC has obtained consulting support from Discern, LLC for refining the payment approach and integrating the quality measures in the reward structure. Discern, LLC staff have assessed the benefits of two approaches:

1. Performance on the quality measures is part of the shared saving formula. For example, 40 percent of the shared savings available to the practice could be distributed based on achieving minimal quality thresholds, with 60 percent of the available savings distributed because the savings were achieved; or
2. Performance on the quality measures is a criterion for participation in the shared savings achieved through the pilot. Under this approach, a satisfactory performance score is a prerequisite for participating in the financial reward structure.

Patients will be attributed to the practice based on the volume of evaluation and management (E&M) claims associated with each primary care practice. Each practice will be benchmarked against its own historical performance. Risk adjustment for the bonus formula is being explored. The total amount of enhanced reimbursement will be commensurate with anticipated savings. Key decisions regarding rates and the level of risk adjustment (if any) have yet to be made.

Task 3: Resolve Medicaid participation and financing alignment. Determine and resolve barriers to Medicaid participation.

Despite the State's current budget providing direction, the Medical Assistance Administration will participate in the program beginning in July 2011. To ensure seamless integration with the program, the

Medical Assistance Administration leadership has been actively involved in the planning of the program with the goal of maximizing their limited funds. Assuming that the pilot includes 200,000 patients in 50 practices sites, Medicaid has committed to financing the Fixed Payments for approximately 30,000 Medicaid beneficiaries (Table 4)[23] enrolled in Traditional Medicaid or Medicaid MCOs. The Administration is working with the MHCC to determine the best way to engage the most vulnerable practices in the program given the limited funds. Among the approaches currently being discussed are limiting the number of high volume Medicaid practices or asking high volume Medicaid practices to forgo the upfront Fixed Payment in exchange for a larger retrospective incentive payment.

Table 4. Estimated Additional Funding for IT Transformation, Care Management Fees, and Care Coordination Payments FY 2012-2014 in PCMH Pilot

		Year 1	Year 2	Year 3	Total
Private Patients	**Covered lives**	170,000	170,000	170,000	170,000
	Total PMPM Payment (millions)	$10.2	$10.4	$10.7	$31.3
	IT Transformation	$30.6	$20.4	$13.6	$52.4
	Care Coordination	TBD	TBD	TBD	TBD
Medicaid Patients	**Covered lives**	30,000	30,000	30,000	30,000
	Total PMPM Pay. (millions)	$1.8	$1.8	$1.9	$5.5
	Practice/IT Transformation	$0.5	$0.4	$0.2	$1.1
	Care Coordination	TBD	TBD	TBD	TBD

Assume hypothetical PMPM payments of $5.0 in year 1, increasing to $5.12 in year 2, and $5.25 in Year 3. PMPM payments have been inflated by projected change in the Medical Economic Index ("MEI") in 2012 and 2013 respectively, which are 2.4 and 2.5 percent. We assume full IT funding levels at the maximum available from ARRA up to $38,000 per provider over the 3 year pilot. We assume that 15 percent of providers would opt for HIT funding through Medicaid, which would be slightly (roughly 10 percent) higher.

[23] Approximately 12 percent of the under 65 population is enrolled in the Medicaid program in Maryland.

Task 4 – Establish the PCMH pilot outreach program to practices, employers, and consumers.

The PCMH pilot outreach program to medical practices and employers is underway; plans for outreach to Maryland's patient community continue. DHMH staff and media consultants have generated awareness among practices in the PCMH by:

- Engaging provider organizations;
- Creating a PCMH portal for providers on the MHCC website;
- Identifying local champions who serve as spokespersons for policy legislative, and media activities.
- Obtaining "earned media" in local newspapers and television news programs and strategically distributing information on PCMH in professional and public media outlets.
- Hosting seven symposia throughout Maryland for providers to learn more about patient centered medical homes and the pilot.

June 22, 2010	Baltimore, MD
June 23, 2010	Cambridge, MD
June 29, 2010	Bethesda, MD
June 30, 2010	Columbia, MD
July 13, 2010	Hagerstown, MD
July 14, 2010	Bel Air, MD
August 26, 2010	National Harbor, MD

- Hosting a webinar series for primary care practices interested in Pilot participation
- A primary focus of the outreach activities for employers has been to focus on more fully engaging self-insured employers.

PCMH Program staff have coordinated program elements with the Council's other projects to the extent possible. A media consultant currently under contract to MHCC was tasked with developing Maryland-specific materials to promote the effort. When possible, publicly available media resources from the Patient Centered Primary Care Collaborative (PCPCC) have been used. Press releases have been widely distributed and articles regarding the Pilot program have been published in the *Baltimore Sun, Baltimore Business Journal, The Sentinel* (Annapolis), and the *Washington Post.*

Task 5 – Determine Transformation Support Approach

The planning for transformation support and the learning collaborative is underway. Some first generation pilots have set aside funds specifically for transformation expenses associated with practices moving from traditional care delivery to the PCMH. There was consensus among Workgroup participants that it is best to avoid a decentralized, uncoordinated approach to practice transformation support. Stakeholders support providing practices with the services of a consultant who can work with practices on work-flow redesign, team building, open access, and other elements of transformation. These activities will be included in the Learning Collaborative that is

currently in the development stage. Workgroup participants have noted that practices most desire ready-to-deploy, practical materials (e.g., specialist referral contract templates, opt-out forms for patients, quality measurement and registry tools, and NCQA recognition readiness assessments).

The Maryland Community Health Resources Commission has approved a grant of $300,000 to the Pilot program for transformation support to participating safety net practices and partial funding of the learning collaborative component of the Pilot program.

Task 6 - Identify Care Coordination Resources

The Workgroup has adopted recommendations and sources of funding and personnel for care coordination. Care coordinators are a critical element in the team approach to care delivery in a PCMH. The Pilot program staff have identified consultants to assess approaches for staffing care coordination across participating practices. Some pilots have financed the care coordination function through direct funding by the state or by payers, and others have left care coordination to the practices. Due to continuing State budget crises, it is unlikely that the State can identify a funding source. Care Coordination has now been assumed to be included in the PPPM fixed payment to practices and will be determined by participating PCMH Pilot practice champions.

Task 7 - Identify Evaluation Approach and Funding Source

The MHCC has identified $450,000 of its reserve as the funding source. Many of the first generation multi-payer pilots financed the evaluation through grants from the Commonwealth Fund, but additional funding from that source is unlikely. The Pilot program staff have procured a consultant to examine approaches used by other pilots. The PCMH Pilot team has been reviewing examples of strong evaluation RFP responses and has sought advice from Melinda Abrams of The Commonwealth Fund, through the assistance of NASHP, to discuss evaluation in greater detail.

Task 8 – Carrier and Provider Participation Agreements

A draft participation agreement is nearly complete. MHCC's Assistant AG is working with the Pilot's program staff and participating carriers' representatives to develop a uniform Participation Agreement to be executed by the parties.

Participating Practices

Participating practices in the Maryland Multi-Payer PCMH Program represent diverse service types and locations, which is ideal to serve a broad base of Maryland patients. MHCC received applications from 179 practices with over 1,000 physicians, reaching 1.4 million patients, far exceeding recruitment goals. Among all selected practices,[24] there will be four or five Federally Qualified Health Centers (FQHCs), seven solo providers, as well as minority-led practices and Certified Registered Nurse Practitioners (CRNPs). 31-33 will be single specialty practices and 18 will be multi specialty practices. Selected practices will also cover the areas of Central Maryland (26), DC Metro (12), Eastern Shore (5), Southern Maryland (6) and Western Maryland (12).

[24] Participating practices will be announced in January 2011. A complete list of practices will be posted on the Council's website: http://www.dhmh.state.md.us/mhqcc

Additionally, two to three virtual practices (composed of a small number of solo practitioners that agree to work together) will also be selected.

Timeline

The Workgroup developed a timeline (Table 5) and identified major cost components of the pilot. The Timeline assumes that planning would continue through 2009 and into 2010. Carriers would make a commitment to participate in 2010. Once carrier participation was confirmed, obtaining practice participation would begin. Practice PCMH awareness symposia would be sponsored by the State and other pilot participants during the summer of 2010. 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. Carriers may independently determine if they wished to continue utilization of the PCMH model.

At the December 10 meeting, the Council accepted the PCMH Workgroup's work as complete. A new PCMH Advisory Committee will begin meeting in 2011, composed of Council members and representatives from participating carriers and practices. The Committee will advise the Maryland Health Care Commission's PCMH staff regarding the operation of the pilot and its evaluation and will report on the status of Maryland's Patient Centered Medical Home program to the Quality and Cost Council periodically.

Table 5. PCMH Pilot Timeline

June 2010	Outreach symposia for providers begin.
July 2010	MHCC releases reward structure and practice performance requirements.
August 31, 2010	Deadline for practices to submit an expression of interest in pilot participation. Providers must notify MHCC if they are interested in participating.
October 23, 2010	Deadline for practices to submit application to participate.
November 30, 2010	Selection committee completes selection process
December 29, 2010	Deadline for carriers to sign participation agreement. Deadline for practices to sign participation agreement.
January 4, 2011 January 2011	Launch of practice transformation and learning collaborative. Carriers provide enrollee rosters for attribution.
February 2011	MHCC releases patient attribution results.
March 2011	Private carriers begin paying PPPM fixed payments to practices that attest to meeting NCQA criteria.
June 30, 2011	Deadline to submit applications to NCQA's Physician Practice Connections– Patient-Centered Medical Home for recognition.
July 2011	PCMH practices begin receiving payments from Medicaid MCOs.

WORKGROUP BENCHMARKS AND TIMELINE

Wellness and Prevention Benchmarks – Healthiest Maryland Businesses:
By **June 2011**, disseminate preliminary evaluation results to Council members.
By **December 2011**, launch Healthiest Maryland Communities.

Evidence-based Medicine Benchmarks – Hand Hygiene:
By **Spring 2011**, begin to use a compliance report card for hospitals.
In **2011**, add new hospital members, and possibly expand to non-acute settings.
Evidence-based Medicine Benchmarks – Blood Wastage:
By **October 2011**, reduce the wastage rate for both plasma and platelets by an additional .5%.
Evidence-based Medicine Benchmarks – Regulated Medical Waste
By **January 2011**, set up a website for the medical waste taskforce, finish designing a standardized tool to collect waste data and kick off the first year of data collection.
Evidence-based Medicine Benchmarks – Telemedicine:
By **January 2011**, begin meetings of Clinical Advisory Group to include physicians with particular disease area expertise.
By **April 2011**, begin meetings of Technical Solutions and Standards Advisory Group to include hospital and governmental IT leaderships.
By **July 2011**, begin meetings of Financial and Business Model Advisory Group to meet with payers.
By **December 2010**, submit Draft Final Report to the Quality and Cost Council.
By **January 2011**, submit Final Report to the Governor.

Patient Centered Medical Home Benchmarks:
By **January 2011**, launch practice transformation and learning collaborative. Conduct employer outreach meetings.
By **February 2011**, MHCC releases patient attribution results.
By **March 2011**, private carriers begin paying PPPM fixed payments to practices that attest to meeting NCQA criteria.
By **June 30, 2011**, submit applications to NCQA's Physician Practice Connections– Patient-Centered Medical Home for recognition.
By **July 2011**, PCMH practices begin receiving payments from Medicaid MCOs.

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)
Katie Jones
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
May 17, 2010
Sept. 18, 2010
Nov. 19, 2010

Evidence-based Medicine Workgroup

Council Members
Chip Davis (Chair)
James Chesley
Barbara Epke
Leslie Simmons
Kathi White
Roger Merrill
Peggy O'Kane

Staff
Mary Mussman
Nicole Stallings

Other Participants
Pam Barclay, MHCC
Patrick Chaulk, Maryland Patient Safety Committee
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

Red Bag Waste Workgroup
TBD, *MHA – ad hoc*
Laura Brannen, *AHA – ad hoc*
I-Fong Sun, Sean Nelson, Zahi Jurdi, *JHM*
Denise Choiniere, *UMMC*
Michael Forthman, Barb Colleran *GBMC*
TBD, *Union Hospital of Cecil County*
Mary Mussman, Nicole Stallings, Cliff Mitchell, *DHMH*
Russ Moy, Dave Long, *DHMH, State Chronic Hospitals*

Ed Hamburg, *MDE*

Telemedicine Task Force

Eric M. Aldrich, Johns Hopkins School of Medicine
Barney Stern, University of Maryland School of Medicine
Richard Alcorta,Maryland Institute for Emergency Medical Services Systems (MIEMSS)
Anna Aycock, Maryland Institute for Emergency Medical Services Systems (MIEMSS)
Robert Bass, Maryland Institute for Emergency Medical Services Systems (MIEMSS)
Patricia Cameron, MedStar Health
Dianne Feeney, Maryland Health Services Cost Review Commission (HSCRC)
Amie Hsia, Washington Hospital Center Stroke Center
Surina Ann Jordan, Zima Health, Maryland State Advisory Council on Heart Disease and Stroke
Frank Monius, Maryland Hospital Association
Mary Mussman, Maryland Department of Health and Mental Hygiene (DHMH)
Alex Nason, Johns Hopkins Health System Office of Telemedicine
Laura Pimentel,Maryland Chapter of American College of Emergency Physicians (ACEP)
Jill Porter, Maryland Board of Physicians
David Sharp, Maryland Health Care Commission (MHCC)
Nicole Stallings, Maryland Department of Health and Mental Hygiene, Office of the Secretary
Jennifer Witten, American Heart Association/American Stroke Association
Christopher Wuerker, M.D., Washington Hospital Center

Evidence Based Medicine Workgroup Meeting Dates:

January 12, 2010
February 3, 2010
February 9, 2010
April 8, 2010
May 6, 2010
May 29, 2010
July 15, 2010
September 9, 2010
October 13, 2010

Patient Centered Medical Home Workgroup

Council Members
Barbara Epke
Roger Merrill
Kathi White (Chair)

Staff
Rebecca Perry
Ben Steffen
Karen Rezabek
Nicole Stallings
Grace Zaczek
Eva DuGoff

Work Group Participants from State Agencies
Rex Cowdry, MD, MHCC
John Folkemer, Maryland Medicaid
Dan O'Brien, DHMH
Robert Murray, HSCRC
Maria Prince, MD, DHMH
Tricia Roddy, Maryland Medicaid
Elizabeth Sammis, MIA
Susan Tucker, Maryland Medicaid
Suellen Wideman, MHCC
Brenda Wilson, MIA

Participants
Salliann Alborn, Maryland Community Health System
Tricia Barret , NCQA
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
Scott Feeser, Johns Hopkins Medicine
Judy Fennimore, Marriott
Darlene Fleischmann, MedChi
Richard Fornadel, Aetna
Kathy Francis, MHCC
Ray Granberry, AARP
Marti Grant, DHMH
Hank Greenberg, AARP
Sheila Higdon, Johns Hopkins Medicine
Christine Barbara Johnson, TransforMED
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
David Reynolds , Coventry
Elizabeth Menachery, Howard County Health Department
John Miller, Mid-Atlantic Business Group on Health
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
Elisabeth 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
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
Suellen Wideman, MHCC

Jay Wolvovsky, Baltimore Medical System

PCMH Workgroup Meeting Dates

February 11, 2010	PCMH Workgroup
April 29, 2010	PCMH Workgroup
May 07, 2010	Outreach and Provider Engagement subgroup
June 16, 2010	PCMH Workgroup

Regional Provider Meetings

June 22, 2010	Baltimore
June 23, 2010	Cambridge
June 29, 2010	Bethesda
June 30, 2010	Columbia
July 13, 2010	Hagerstown
July 14, 2010	Bel Air
August 26, 2010	National Harbor

APPENDIX B: SELECT WELLNESS AND PREVENTION PROVISIONS IN THE AFFORDABLE CARE ACT

Prevention and Public Health Fund (Sec. 4002) Establishes a fund, to be administered through the Office of the Secretary at HHS, to provide for an expanded and sustained national investment in prevention and public health programs (over the FY 2008 level). The Fund will support programs authorized by the Public Health Service Act, for prevention, wellness and public health activities, including prevention research and health screenings and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs. Funding levels: FY 2010 - $500 million; FY2011 - $750 million; FY 2012 - $1 billion; FY 2013 - $1.25 billion; FY 2014 - $1.5 billion; FY 2015 and each fiscal year thereafter- $2 billion.

Community Transformation Grants (Sec. 4201) – Authorizes CDC to award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Eligible entities shall submit to the Director a detailed plan including the policy, environmental programmatic and as appropriate infrastructure changes needed to promote healthy living and reduce disparities. Activities may focus on creating healthier school environments, creating infrastructure or programs to support active living and access to nutritious foods, smoking cessation and other chronic disease priorities; implementing worksite wellness; working to highlight healthy options in food venues; reducing disparities; and addressing special population needs. The section includes evaluation and reporting requirements.

National Diabetes Prevention Program (Sec. 5316) - Creates a CDC National Diabetes Prevention Program targeted at adults at high risk for diabetes, which entails a grant program for community-based diabetes prevention program model sites.

Nutrition Labeling of Standard Menu Items at Chain Restaurants (Sec. 4205) – Establishes nutrition labeling of standard menu items at chain restaurants (20 or more locations doing business under the same name). This includes disclosing calories on menu boards and in a written form, available on request, additional information pertaining to total calories and calories from fat, amounts of fat and saturated fat, cholesterol, sodium, total and complex carbohydrates, sugars, dietary fiber, and protein.

Healthy Aging, Living Well; Evaluation of Community-Based Prevention; and Wellness Programs for Medicare Beneficiaries (Sec. 4202) - Authorizes the Secretary, acting through the CDC Director, to award competitive grants to health departments and Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and when necessary, clinical referrals for individuals who are between 55-64 years old. Grantees must design a strategy to improve the health status of this population through community based

public health interventions. Intervention activities may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health and promote healthy lifestyles among the target population. Screenings may include mental health/behavioral health and substance abuse disorders; physical activity, smoking and nutrition; and any other measures deemed appropriate by the Secretary. The section includes an evaluation component. The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries. The evaluation shall include programs sponsored by the Administration on Aging that are evidence-based and have demonstrated potential to help Medicare beneficiaries reduce their risk of disease, disability and injury by making healthy lifestyle choices. CMS and AOA shall also conduct an evaluation of exciting community prevention and wellness programs. The Secretary shall submit a report to Congress on recommendations to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries; relevant findings; and the results of the evaluation.

Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid (4107) - States would be required to provide Medicaid coverage for counseling and pharmacotherapy for tobacco cessation by pregnant women. Prohibits cost-sharing for these services.

Incentives for Prevention of Chronic Diseases in Medicaid (Sec. 4108) – Directs the Secretary to award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who successfully participate in a healthy lifestyles program and demonstrate changes in health risk and outcomes. The program shall be comprehensive, evidence-based, widely available, and easily accessible and shall be proposed by the state and approved by the Secretary. It shall be designed to address the needs of Medicaid beneficiaries to achieve: ceasing the use of tobacco; controlling or reducing weight; lowering cholesterol; lowering blood pressure; avoiding the onset of diabetes or improving management of diabetes. The programs shall last for 5 years. The section includes impact assessments, evaluation and reporting requirements. The section appropriates $100 million for the program, out of any funds not otherwise appropriated in the Treasury.

Employer-Based Wellness Programs (Sec. 4303) – Directs CDC to provide employers with TA, consultation and tools in evaluating wellness programs and build evaluation capacity among workplace staff. Directs CDC to study and evaluate employer-based wellness practices. Clarifies that any recommendations, data or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.

Grants for Small Businesses to Provide Comprehensive Workplace Wellness Programs (Sec. 10408) - Directs the Secretary to award grants to small businesses

Reasonable Break Time for Nursing Mothers. Amends the Fair Labor Standards Act of 1938 to require that employers provide a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth and provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public.

Research on Optimizing the Delivery of Public Health Services (Sec. 4301) – Directs the Secretary, acting through the CDC Director, to fund research in the area of public health services and systems. Research shall include examining best practices relating to prevention, with a particular focus on high priority areas identified by the Secretary in the National Prevention Strategy or Healthy People 2020; analyzing the translation of interventions to real-world settings; and identifying effective strategies for organizing, financing or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

APPENDIX C: HEALTHIEST MARYLAND BUSINESSES

	Company:	County:	Type of Industry
1	A&G Pharmaceutical Inc.	Howard County	Health Care and Social Assistance
2	ACT Personnel Service, Inc.	Allegany County	Professional, Scientific, and Technical Services
3	Adventist Healthcare	Montgomery County	Health Care and Social Assistance
4	AEGON	Baltimore City	Finance and Insurance
5	AES Warrior Run	Allegany County	Utilities
6	Aetna	State-wide	Finance and Insurance
7	Alliant Tech Systems	Out-of-State	Manufacturing
8	American Diabetes Association Maryland Office	Baltimore City	Health Care and Social Assistance
9	Anderson, Coe & King, LLP	Baltimore City	Professional, Scientific, and Technical Services
10	Anne Arundel Medical Center	Anne Arundel County	Health Care and Social Assistance
11	Atlantic General Hospital	Worcester County	Health Care and Social Assistance
12	Audacious Inquiry	Howard County	Management of Companies and Enterprises
13	Ayers/Saint/Gross	Baltimore City	Professional, Scientific, and Technical Services
14	Baltimore City Community College	Baltimore City	Educational Services
15	BCPS	Baltimore County	Educational Services
16	BioMarker Strategies	Baltimore City	Professional, Scientific, and Technical Services
17	BOC International	Baltimore County	Health Care and Social Assistance
18	Bon Secours Baltimore Health System	Baltimore City	Health Care and Social Assistance
19	Business Health Services	Baltimore City	Professional, Scientific, and Technical Services
20	Calvert Memorial Hospital	Calvert County	Health Care and Social Assistance
21	Calvin B. Taylor Banking Company	Worcester County	Finance and Insurance
22	CareFirst BlueCross BlueShield	Baltimore County	Finance and Insurance
23	Carroll Community College	Carroll County	Educational Services
24	Carroll Hospital Center	Carroll County	Health Care and Social Assistance
25	Chester River Health System	Kent County	Health Care and Social Assistance
26	City of Cumberland	Allegany County	Public Administration
27	City of Frederick	Frederick County	Public Administration
28	City of Rockville	Montgomery County	Public Administration
29	City of Salisbury	Wicomico County	Public Administration
30	Clear Channel Outdoor	Wicomico County	Other Services (except Public Administration)
31	College of Notre Dame	Baltimore City	Educational Services
32	Community College of Baltimore County (Dundalk)	Baltimore County	Educational Services

33	David Edward	Baltimore County	Manufacturing
34	Deutsch & Associates, LLC	Montgomery County	Finance and Insurance
35	Easton Utilities	Talbot County	Utilities
36	Erickson Retirement Communities	State-wide	Real Estate and Rental and Leasing
37	Forest City - NEBP	Baltimore City	Construction
38	Friends Aware	Allegany County	Other Services (except Public Administration)
39	G.1440	Baltimore City and Howard County	Professional, Scientific, and Technical Services
40	Garrett County Memorial Hospital	Garrett County	Health Care and Social Assistance
41	George, Miles & Buhr	Wicomico County	Professional, Scientific, and Technical Services
42	Gliknik Inc.	Baltimore City	Professional, Scientific, and Technical Services
43	Goodwill Industries of the Chesapeake, Inc.	Baltimore City	Other Services (except Public Administration)
44	Grant Thornton	Baltimore City	Finance and Insurance
45	Greater Maryland Medical Center	Baltimore City	Health Care and Social Assistance
46	Harford Community College	Harford County	Educational Services
47	Health Care for the Homeless	Baltimore City	Health Care and Social Assistance
48	Hord Coplan Macht, Inc.	Baltimore City	Other Services (except Public Administration)
49	Howard County Health Department	Howard County	Public Administration
50	Johns Hopkins Health System / Johns Hopkins Hospital	Baltimore City	Health Care and Social Assistance
51	K&L Microwave, Inc	Wicomico County	Manufacturing
52	Kaiser Permanente	Uknown	Finance and Insurance
53	Kelly & Associates Insurance Group	Baltimore County	Finance and Insurance
54	Kent County Health Department	Kent County	Health Care and Social Assistance
55	Kent County Public Schools	Kent County	Educational Services
56	Life Fitness Management	Allegany County	Other Services (except Public Administration)
57	LifeBridge Health	Baltimore City and Baltimore County	Health Care and Social Assistance
58	Marriott International	Montgomery County	Accomodation and Food Services
59	Maryland Hospital Association	Howard County	Health Care and Social Assistance
60	McCormick & Company, Inc.	Baltimore County	Manufacturing
61	Medifast, Inc	Baltimore County	Other Services (except Public Administration)
62	MedStar Health, Inc.	Howard County	Health Care and Social Assistance
63	Mel's Business Systems, Inc	Allegany County	Retail Trade
64	Mid-Delmarva Family YMCA	Wicomico County	Arts, Entertainment, and Recreation
65	Miltec Corporation	Queen Anne's County	Manufacturing
66	Montgomery College	Montgomery County	Educational Services
67	Mt Washington Pediatric Hospital	Baltimore City	Health Care and Social Assistance
68	National Aquarium	Baltimore City	Arts, Entertainment, and Recreation

69	New Windsor State Bank	State-wide	Finance and Insurance
70	Novartis Pharmaceuticals	State-wide	Health Care and Social Assistance
71	Peninsula Regional Medical Center	Wicomico County	Health Care and Social Assistance
72	Perdue	Anne Arundel and Wicomico County	Agriculture, Forestry, Fishing and Hunting
73	PNC Bank	State-wide	Finance and Insurance
74	QIAGEN	Montgomery County	Manufacturing
75	Richard J Princinsky and Associates	Baltimore County	Finance and Insurance
76	RIggs, Counselman, Michaels & Downes	Baltimore County	Finance and Insurance
77	RSM McGladrey	Baltimore County	Professional, Scientific, and Technical Services
78	Rummel, Klepper & Kahl LLP (RK&K)	Baltimore City	Professional, Scientific, and Technical Services
79	Saint Agnes Hospital	Baltimore City	Health Care and Social Assistance
80	Shore Health System	Dorchestor County	Health Care and Social Assistance
81	SMECO	Charles County	Utilities
82	Spirit Creative Services, Inc.	Anne Arundel County	Arts, Entertainment, and Recreation
83	State of Maryland	State-wide	Public Administration
84	TBC	Baltimore City	Other Services (except Public Administration)
85	The Aspen Group, Inc.	State-wide	Professional, Scientific, and Technical Services
86	The Bank of Delmarva	Wicomico County	Finance and Insurance
87	The Horizon Foundation	Howard County	Other Services (except Public Administration)
88	The PharmaCareNetwork	Allegany County	Health Care and Social Assistance
89	Thrasher Engineering	Garrett County	Professional, Scientific, and Technical Services
90	Total Biz Fulfillment, Inc	Garrett County	Transportation and Warehousing
91	Ulman Cancer Fund for Young Adults	Howard County	Other Services (except Public Administration)
92	Union Hospital of Cecil County	Cecil County	Health Care and Social Assistance
93	United Healthcare	State-wide	Finance and Insurance
94	University of Maryland Baltimore	Baltimore City	Educational Services
95	University of Maryland School of Medicine	Baltimore City	Health Care and Social Assistance
96	Upper Chesapeake Health	Harford County	Health Care and Social Assistance
97	Verizon	State-wide	Other Services (except Public Administration)
98	Western Maryland Area Health Education Center (AHEC)	Allegany County	Health Care and Social Assistance
99	Western Maryland Health System	Allegany County	Health Care and Social Assistance
100	Wicomico Co. Health Dept.	Wicomico County	Health Care and Social Assistance
101	Wisp Resort	Garrett County	Arts, Entertainment, and Recreation
102	WMDT	Wicomico County	Information
103	Y of Central Maryland	Baltimore City	Health Care and Social Assistance

Healthiest Maryland Businesses - Supporting Organizations

Greater Baltimore Committee
Howard County Health Department
Maryland Hospital Association
Mid-Atlantic Business Group on Health
National Committee for Quality Assurance
Partnership for Prevention
Partnership for a Healthier Carroll County

Healthiest Maryland Businesses - Ambassadors

Johns Hopkins
LifeBridge Health
Marriott International
Perdue Farms
University of Maryland School of Medicine

APPENDIX D: HEALTHIEST MARYLAND BUSINESSES' EVALUATION PLAN

November 2010

The Office of Chronic Disease Prevention has contracted with the Maryland Institute for Policy Analysis and Research (MIPAR) at the University of Maryland Baltimore County to assess Healthiest Maryland Businesses (HMB) and the effectiveness of worksite wellness. This evaluation is viewed as a community participatory research with Maryland businesses.

In year one, the evaluation will provide baseline data on worksite wellness programs and their effects. Year two of the evaluation will focus on how Healthiest Maryland has influenced worksite programs. All of the evaluation components will be repeated in the summer and fall of 2011.

Qualitative and Quantitative Evaluation Components

1) A phone survey of key constituents within the human resources unit at 10 participating businesses will be used to discuss the implementation of worksite wellness programs to develop case studies of best practices. This qualitative study explore implementation, types of programs, use, and familiarity with Healthiest Maryland. This data will be transcribed and analyzed for themes using ATLAS. Data from the phone survey, the Office of Chronic Disease Prevention's (OCDP) "Health Management Initiative" web survey, and BRFSS also will be analyzed in Spring 2011.

2) The "Worksite Wellness for Tompkins County" web survey will be distributed to the human resource managers of at least 300 Maryland businesses and will assess health management strategies. The population will be chosen via random sampling from a list of Maryland firms and a convenience sampling of all participating Healthiest Maryland businesses. Data analyses will assess correlations between firm characteristics (industry, size, year implementation, and use of HMB) and the types of wellness services provided. Data collection and analysis will begin in December 2010 and re-occur in December 2011. A preliminary report will be completed in Spring 2011.

3) A web survey of employees working at companies prior to implementation and 1-year post implementation will gather information regarding utilization of prevention and wellness programs (the index and strength of the programs) as well as employee health outcomes (BMI, physical activity, smoking, alcohol, medical conditions, general health status, and mental health status). It is expected that approximately 100 employees from five companies will be surveyed using a "Health Performance Questionnaire" along with select questions from the advisory group. Random sampling will be utilized based on the number of firms, the firm size, and their willingness to participate. The data analysis will be completed in STATA. The survey will be developed and implemented in February 2011, analyzed in March 2011, disseminated in Summer 2011.

4) Two focus groups of employee participants (with the same number of comparator groups from

nonparticipating companies, totaling four groups) will be questioned regarding the wellness and prevention program's implementation, utilization, and outcomes. These qualitative study results will establish case studies and provide data regarding program improvement. This data will be analyzed using ATLAS. The focus groups are planned for January/February 2011 with the analysis and preliminary report to be completed in Summer 2011.

5) An individual medical claims assessment of 2-3 participating companies is the final component of the Healthiest Maryland Business evaluation. It is proposed that claims 1-year prior, during, and 1-year post implementation will be examined for utilization (outpatient, hospitalization, ED, prescription drug use) in total as well as by key chronic diseases. Health care expenditures related to key areas- diabetes, asthma, cardiovascular, and depression- will be compared by type of wellness program, and analyzed with STATA. The goal is to compare this data to a national utilization data set, such as the Medical Care Expenditure Panel Survey. This data will be secured in March 2011 and begin analysis in April 2011.

MARYLAND HEALTH CARE COMMISSION

APPENDIX E

Healthcare-Associated Infections Data Collection and Reporting

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 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*, which may also be accessed on the website: http://mhcc.maryland.gov/healthcare_associated_infections/index.html. With the guidance of a standing 21-member HAI Advisory Committee, the MHCC has been implementing the recommendations of the TAC in stages.

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 two SCIP infection prevention measures, effective for discharges after January 1, 2009: cardiac surgery patients with controlled 6 a.m. postoperative serum glucose (SCIP-INF-4); and surgery patients with appropriate hair removal (SCIP-INF-6). Data for the expanded SCIP measures were reported on the Hospital Guide beginning in January 2010.

Effective January 1, 2009, Maryland hospitals were required to collect and report quarterly data on Active Surveillance Testing (AST) for methicillin resistant Staphylococcus aureus (MRSA) in Intensive Care Units (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. This data is updated on the Hospital Guide quarterly.

Public reporting for two additional HAI measures began in 2010, including data on Health Care Worker (HCW) Influenza Vaccination Rates and Central Line-Associated Blood Stream Infections. The Centers for Disease Control and Prevention have long recommended annual influenza vaccinations for all HCWs. The National Quality Forum includes influenza vaccination of health care workers as one of its 34 safe practices that should be utilized universally to reduce risk to patients. All Maryland hospitals are currently collecting a uniform data set on HCW influenza vaccination rates. Using an online survey instrument, hospitals are collecting aggregate data on all paid, full-time and part-time employees and house staff (defined as residents and interns) who received FluMist® or an injectable flu vaccine on-site or off-site between September 1st and April 15, 2010. Data on hospital HCW influenza vaccination rates for the 2009-2010 period were reported on the Hospital Guide in July 2010. In October 2010, data on central line-associated blood stream infections (CLABSIs) in adult and pediatric intensive care units (ICUs) and Level II/III and III neonatal intensive care units (NICUs) were reported on the Hospital Guide. This new data includes information on CLABSIs experienced in Maryland acute care hospitals for the 12-month period, July 1, 2009 through June 30, 2010.

Effective July 1, 2010, the MHCC required all Maryland acute general hospitals to use the National Healthcare Safety Network (NHSN) system to report Surgical Site Infections (SSIs) for three operative procedure categories: knee replacement surgery; hip replacement surgery; and, coronary artery bypass graft (CABG) surgery. The MHCC will publicly report information on SSIs for these three procedure categories in 2011-2012.