Maryland Health Quality and Cost Council
UMBC Technology Center
December 12th 2008
12-3:30
Meeting Minutes

Members present: E. Albert Reece, Peggy O'Kane, Chip Davis, James Chesley, Barbara Epke, John Colmers (Vice-Chair), Chris Stefanides, Jill Berger, Roger Merrill, Kathleen White.

Members absent: Lt Gov Anthony Brown, Debbie Chang, Thomas LaVeist and Reed Tuckson.

Staff: Lydia Isaac, Susan Milner, Fran Phillips, Jeanette Ortiz, Audrey Regan

Review of Minutes, Vision and Mission Statements

The meeting was called to order at 12:12pm. A motion was moved and seconded at 12:16 pm to adopt the minutes as presented. Secretary Colmers introduced Susan Milner who is serving as a consultant to the council and will be working closely with staff to advance the council's goals.

A brief discussion of the mission and vision included revising both statements. The vision statement was revised to include references to the attainment of health and high quality healthcare, as the focus of the council is to improve the health of the population health as well as improve the medical delivery system.

The council discussed including concepts of population level heath, cost containment, and maximizing efficiency and effectiveness given limited resources. Also, to be consistent with the vision statement, the council agreed that the concept of high quality health care be worked into the mission statement. The chair suggested that the staff work on the semantics and circulate a revised version to council members at a later date.

Panel on Maryland's Innovative Private Sector Initiatives

The panel began with presentations from two council members, Jill Berger and Barbara Epke, followed by a presentation by Jon Shematek, Senior Vice President and Chief Medical Officer from CareFirst BlueCross BlueShield

Jill Berger from Marriott International discussed programs her organization has initiated to improve the health of employees. Marriott has over 90,000 associates, 70 percent of whom are in HMOs across the country. The organization spends $4 million on healthcare each year. When Marriott increased its drug plan copays, it started to see unintended health consequences, especially among those with chronic diseases. The company realized that they had to find a way to deliver essential care that their employees needed while paying attention to costs, cultural differences, and quality. As one part of a solution, they chose to implement a value-based formulary design run by Active Health Management. The program offers significantly reduced drug copays for employees with prevalent chronic conditions, such as diabetes and cardiovascular disease. After one year, the program has been a break-even proposition in terms

of medical costs. However, potential cost savings from reduced disability or increased worker productivity have not yet been measured. Ms. Berger indicated that investigating the program over longer periods of time and tracking additional variables may indicate whether this program is a truly viable solution.
http://dhmh.state.md.us/mhqcc/pdf/dec08/Berger_MHQCC_121208.pdf

Barbara Epke of LifeBridge Health presented on the initiatives underway at Sinai Hospital, many of which are also occurring at hospitals across Maryland. Ms. Epke spoke about the importance of safety and quality in hospitals, the need for greater partnering, and the importance of buy-in among all members of the hospital staff. She described a program to reduce falls that included not only the clinical staff but also the hospital's maintenance staff.

She indicated that hospitals in Maryland have collaborations with the Maryland Patient Safety center on three major initiatives: a perinatal collaborative to reduce infant harm; an emergency department collaborative to build more coordinated ED teams, reduce infections, and increase appropriate medication dispensing; and a MRSA prevention initiative. Ms Epke highlighted the importance of innovation and use of technology to improve safety and increase quality.
http://dhmh.state.md.us/mhqcc/pdf/dec08/Epke12_12_08_Final.pdf

Dr. Jon Shametek, with CareFirst BlueCross BlueShield presented on the organization's patient-centered primary care medical home pilot project that will be launched in January 2009. The program is designed to address the four root causes of sub-optimal care: namely, complexity, lack of coordination, slow adoption of technology, and payment system issues. The program is voluntary and is seeking NCQA recognition. The pilot program will involve 10-12 practices, each of which will have a transformation consultant to help with coordination of care and reporting requirements. Practices will receive outcome measures on ER hospitalizations and avoidable admissions for their patients. Practices will receive up to $100, 000 annually if all goals are met. http://dhmh.state.md.us/mhqcc/pdf/dec08/Shematek_PCMH_MHQCC_12-08.pdf

The panel members agreed that the way to improve quality is to have continued engagement, collaboration and partnership of all stakeholders such as those represented on the panel (i.e., employers, payers, medical providers, and insurance coverage providers). Following the panelists' presentations, Ms. Milner indicated that we should use their information as a starting point so that we may build an inventory of innovative private sector initiatives currently taking shape across the state.

The discussion involved looking at the other aspects that affect quality, such as cultural factors, patient education about self-management, and disease status—aspects that are not always fixed with price. One council member suggested that greater interaction between patients and medical professionals yields increased compliance and improvement in health, which, in turn, will reduce costs; copays do not fix issues with compliance. Dr. Shametek described an innovative collaborative in Delaware in which six hospitals—all in different systems—have partnered with Carefirst to do a rigorous evaluation of the medical home model. The panel participants noted that an increase in the number of collaborative interventions and greater collection and use of high quality data will improve the health system's ability to make changes. Several members

pointed out that their organizations need to do more outside of their four walls to reduce problems such as hospital readmissions, poor care coordination, and negative health outcomes.

Panel on Chronic Disease Management Plan

The panel was moderated by Frances Phillips, DHMH Deputy Secretary for Public Health Services. Audrey Regan, PhD of DHMH's Office of Chronic Disease Prevention gave an overview of the Chronic Care Model, focusing in particular on the public health and community aspects of the model. Originally developed by Dr. Wagner from University of California, the model was subsequently expanded to the "Expanded Chronic Care model," which more thoroughly articulates the public health role. This theoretical framework is utilized by the Office of Chronic Disease Prevention, the Vermont Blue Print for Health, Pennsylvania, New Jersey, North Carolina, and Colorado. Analysis has revealed that interventions containing at least one component of the CCM improved clinical outcomes and the quality of care, especially creating prepared practice teams (PPT) or team-based management (Bodenheimer, 2007; Bondenheimer, 2002; Hroscikoski, 2006; Tsai, 2005).

Dr. Regan explained the components fully with Health Systems organization. First, information system is necessary for providers to have patient data, coordinated practice guidelines, and smooth office flow. Second, decision support refers to treatment decisions need to be based on explicit, proven guidelines supported by clinical research. Third, delivery system design is transforming a system that is essentially reactive to one that is proactive. Then, Dr. Regan discussed Patient Self Management Education (PSME), which is on the cusp, straddled between health care systems and public health. Despite offerings in clinical and community settings, data suggest that approximately 50 percent of diabetes in Maryland receive any PSME.

Dr. Regan then emphasized that there are other social determinants of health, such as social or environmental stressors, transportation, healthy housing, which the published literature indicate play a larger in population's overall health than perhaps direct clinical care. The first component is strengthen community action, which is working with community groups to set priorities and achieve goals that enhance community health. Grassroots organizing can be critical components of community change. The second component is create supportive environments, which is generating living and employment conditions that are safe, stimulating, satisfying and enjoyable. The third component is build healthy public policy, which is the development and implementation of policies designed to improve population health. The presentation is available at: http://dhmh.state.md.us/mhqcc/pdf/dec08/Regan_HQCC_Presentation_12-12-08.pdf

Marge Houy, a Senior Consultant with Bailit Health Purchasing, presented on the experiences of the Pennsylvania Chronic Care Management, Reimbursement and Cost Reduction Commission in implementing a model that integrates concepts from the Chronic Care Model and the Patient-Centered Medical home. The initiative involves regional roll-outs, which started in May 2008 with Southeastern Pennsylvania. The initial focus of the Pennsylvania initiative will be on diabetes and pediatric asthma. The initiative has seven implementation priorities and requires participation from program partners that include state government, primary care practices, and payers. The initiative has to show cost savings after three years in order for it to be sustainable. The initiative includes a learning collaborative among individuals and organizations.

Participating provider practices have coaches from the RWJF Improving Performance in Practice (IPIP) program. Though the initiative has made strides on consumer engagement, engaging patients in their own health is hard to accomplish, according to Houy. She suggested that the council consider implementing a Stanford-type self-management program, but her recommendation was not accepted by the commission. A key objective of the Pennsylvania initiative is to bring together, in a mutually enforcing way, community public health elements and clinical care. For example, some participating physician practices plan to hold farmers markets once a week in their parking lots. Ms. Houy commented that one area where the Pennsylvania initiative is somewhat lacking is in making a strong connection between behavioral health and physical health. http://dhmh.state.md.us/mhqcc/pdf/dec08/PA_Houy_M_121208.pdf

Delegate Shawn Tarrant of the 40th district in Baltimore city provided background on his district and why he sponsored HB 1395. He commented on the high rate of chronic disease and poor lifestyle behaviors in certain parts of his district and the importance of having citizens take a more active role in their health. Delegate Tarrant saw the establishment of the council as a wonderful opportunity to marry the ideas of his bill with the goals already set out in the executive order for the council and include four new items in the councils charge: namely,

- looking at regional differentiation;
- patient education;
- consult with physicians so that they have access to all the best evidence based information; and
- allow the council to accept funds to carryout its goals.

The council's discussion focused on some of the specifics of the Pennsylvania initiative, particularly its funding and use of technology. In Pennsylvania, every practice is paid proportional to the number of patients, physician participation is completely voluntary, and contracts are uniform. Participating practices are not linked electronically, rather every practice uses the same type of mandatory electronic patient registry. Measurement of outcomes for the initiative includes standard NCQA quality measures for diabetes and pediatric asthma. Peggy O'Kane noted that New York City has an innovative program using EHRs rather than patient registries. In New York, the city designs and buys the software while the practice purchases the equipment such as computers. All practices thus use the same platform and can be electronically connected. Ms. Houy indicated that EHRs are a more effective option; however, Pennsylvania did not have sufficient funds to implement such an option. Registries were selected instead because they are significantly less expensive.

<u>What are the Characteristics of Effective Quality Councils?</u>

Daniel Fox, PhD of the Milbank Memorial Fund presented on the characteristics of effective quality councils using examples from North America and abroad. Councils formed by government entities are at the convergence of science and governance, he noted. Dr. Fox outlined six characteristics of effective councils:

1. Broad and deep stakeholder involvement
2. Commitment to rigorous measurement and public reporting
3. Governing with an expert board that works closely with staff to shape goals

4. The conviction that effective quality improvement goes beyond the avoidance of blaming and shaming members of the healthcare workforce to include as well genuine concern for both their professional satisfaction and the satisfaction of their patients
5. Skillful use of the "regulatory shadow" to persuade health professionals and provider organizations that voluntary action to improve quality and to spend more efficiently is in their best interests
6. Considering access to care as a dimension of quality

Dr. Fox ended his presentation with an equation that sums up his points:
Good Governance + Good Evidence + Modest Resources from Leverage and/or Appropriations = A Quality Council that can Accelerate Effectiveness, Efficiency and Quality Improvement.

One council member asked about the ability to transfer ideas from different councils to other communities and whether councils have to be tailor-made for a particular community. Dr. Fox responded that each local community may implement ideas differently, but the concepts are transportable. Dr. Fox suggests that it is less effective for to export the process by which they make decisions; the criteria that they use in their decision making, however, is likely to be transferable. A council member asked about data—specifically, when and how to measure outcomes. Dr. Fox replied that the council's goal is to either have an established baseline or establish one quickly and measure before and after. Dr. Fox suggested that quality councils in Scotland, England, or British Columbia as good models of how to establish such baselines quickly.

Discussion of Strategic Plan Outline, Workgroups, and Next Steps

The last hour of the council meeting was spent discussing how to organize the work of the council moving forward. John Colmers presented several workgroup options. The first option discussed was the chronic care management plan workgroup (as mandated by legislation). This workgroup will focus on health promotion and disease prevention activities.
http://dhmh.state.md.us/mhqcc/pdf/dec08/MHQCC_Strategic_Plan_JC120908.pdf

John Colmers asked the council to select among options for creating a second workgroup. One option focused the development of a patient-centered medical home. A second option addressed measurement harmonization, reporting, and transparency. And a third option was left open for suggestion.

The council members spent a significant amount of time discussing the details of the chronic care workgroup. Council members discussed whether both the medical home model and prevention should be subsumed under this particular workgroup. One council member suggested, when looking at the chronic care plan, that we decrease copays for screening tests, and pay attention to innovative technology and benchmarking results. Members also felt that there needed to be a greater focus on prevention and wellness. Members also expressed a desire to better differentiate the concepts of medical home and chronic disease care. John Colmers indicated that the chronic care plan group would focus more on community aspects, wellness/prevention, possibly limiting their focus to a certain number of diseases. Several

innovative wellness programs where mentioned, including King County in Washington state and Microsoft worldwide benefits. But even with coordinated programs, reach is limited as only the benefit holder is in the program, not his or her dependents. To increase scope and reach of the workgroups, council members indicated that staff should work to coordinate the different workgroups' activities. This coordination will help to relate the chronic care group's activities, for example, with those of the medical home group.. The council wants the workgroups to focus attention across multiple payers, providers, and communities as much as possible. The goal of the council is to think of these organizations as one multifaceted entity in which the council can design measurable changes.

For the medical home workgroup, a council member pointed out that infrastructure development and political will are needed to implement the medical home model in the state. The same council member felt that the council did not address significant components of quality: namely, measurement and improvement. The member acknowledged that measurement may not be the most exciting thing, but it is important for understanding and trending outcomes.

Chip Davis suggested that the council create another work group that focuses largely on hospital-based practices that could be categorized as "low-hanging fruit": namely, initiatives or programs to improve quality that could be easily and quickly implemented.
In addition, one of the council members suggested creating a workgroup that studies what has been done by other councils both domestically and internationally. The goal of this would be to understand what Maryland could transport from these experiences to help better inform our workgroup activities. John Colmers indicated that such research and information gathering would be implicit in the work of each of the Maryland council's workgroups and that a separate workgroup to gather this information may be redundant.

The Council felt strongly that two or more workgroups (in addition to the chronic care workgroup) were needed. The council ultimately decided to form a primary care medical home workgroup, which will look at what is already being done in Maryland with respect to medical homes as well as other models for strengthening and increasing primary care. The council decided to create an additional workgroup that will focus on implementing statewide evidence-based practices (i.e., "low-hanging fruit" workgroup) and quality improvement initiatives with known results. This group will focus on achieving consensus on validated evidence-based quality improvements standards that can be instituted around the state.

The council members self-selected into each workgroup. The workgroup membership is as follows:

Chronic Care
Peggy O'Kane
Jill Berger
E. Albert Reece
Roger Merrill
James Chelsey

Primary Care Medical Home

Barbara Epke
Chris Stefanides
Roger Merrill
Peggy O'Kane
Chip Davis

Evidence-based Practices (Low-Hanging Fruit)
Chip Davis
James Chesley
Barbara Epke
Jill Berger

The meeting adjourned at 3:43pm.