Maryland Health Quality and Cost Council
March 1, 2010
9:30 a.m. – Noon
UMBC Technology Center

Meeting Minutes

Members present: Sec. John Colmers (Vice-Chair), Jill Berger, Debbie Chang, James Chesley, Richard "Chip" Davis, Barbara Epke, Ed Koza (on behalf of Reed Tuckson), Roger Merrill, Frances Philips, E. Albert Reece, Leslie Simmons, Kathleen White and via telephone, Peggy O'Kane.

Members absent: Lt. Governor Anthony Brown (Chair) and Thomas LaVeist

Staff: Nicole Stallings, Maria Prince, Audrey Regan, Karen Rezabek, Ben Steffen and Ben Stutz

Meeting Materials

All meeting materials are available on the Council's website: http://dhmh.maryland.gov/mhqcc/meetings.html

Welcome and Approval of Minutes

The meeting was called to order at 9:40 with a welcome from Secretary Colmers. The December 18, 2009 minutes were approved.

Updates

Secretary Colmers provided an update of healthcare reform which is changing every day. States immediate focus is on the need for continued ARRA support to get through FY 2011. Maryland's budget picture remains challenging, and there is a $389 million hole without expansion of enhanced FMAP, scheduled to end Jan. 1, 2011. Secretary Colmers commented that while federal reform is not perfect it would do what most states cannot: (1) expand Medicaid across the board to childless adults; (2) require health insurance coverage; (3) establish subsidies for those that cannot afford coverage on their own or do not qualify for Medicaid; and (4) eliminate medical underwriting. In addition, federal reform offers numerous opportunities for states to address other parts of reform through cost containment initiatives, all-payer demonstrations and delivery system reform. Secretary Colmers concluded by commenting that Maryland cannot wait for federal reform to develop HIT infrastructure, reform individual and small group markets, address manpower issues and consider changes to the all-payer system, etc. Maryland will continue to prepare for incremental change while national reforms are debated in Washington.

Secretary Colmers then introduced Dr. Patrick Chaulk, who was recently appointed as Executive Director of the Maryland Patient Safety Center, effective in late March. Dr. Chaulk replaces Dr. Bill Minogue, who is retiring after leading the Maryland Patient Safety Center since its 2004 inception. Secretary Colmers congratulated Dr. Chaulk for his new leadership role and thanked Dr. Minogue for his years of service.

Finally, Secretary Colmers highlighted a recent op-ed, written by Council member Albert Reece, M.D., dean of the University of Maryland School of Medicine and Dr. Edward Miller, dean of the Johns Hopkins University School of Medicine on the importance that prevention needs to play in health care reform in order to effectively cut health care costs while expanding coverage.

Presentation: Maryland's Health Information Technology Infrastructure - Rex W. Cowdry, M.D., Maryland Health Care Commission

Dr. Cowdry began his presentation (available on the MHQCC website) commenting on the potential for Health Information Technology (HIT) to improve health care quality, prevent medical errors, and reduce health care costs by delivering essential information to the time and place of care. HIT is a tool that can help address disparities in cost and quality to the extent that it is a component of new payment strategies and models of care, such as the medical home initiative endorsed by the Council. Further, HIT can also gather information efficiently for better health services research, public health and homeland security surveillance, and quality reporting.

Dr. Cowdry then provided an overview of the development of the state's Health Information Exchange and the policy work being conducted by the Maryland Health Care Commission (MHCC) to support implementation. The presentation then turned to incentives to increase Maryland physician adoption of Electronic Health Records (EHR). Maryland's rate of EHR adoption for a basic system is consistent with the nation, 22 percent of physicians and 77 percent of hospitals. In addition to participation in the CMS EHR Demonstration Project and the incentives in place under the American Recovery and Reinvestment Act, Maryland also passed a law requiring state-regulated payers to provide EHR adoption incentives that paralleled the requirements of the federal law. An Advisory Committee convened by the MHCC, consisting of private payers and other stakeholders are presently evaluating monetary incentive options that would qualify under the new law. Dr. Cowdry said that this requirement aligns with the Council's patient centered medical home (PCMH) initiative, which requires use of an EHR. Payers that actively participate in the PCMH program will be seen as providing incentives for adoption of EHRs, and thus meeting the requirements of the law. The MHCC expects to propose regulations to this effect in 2010.

Dr. Cowdry concluded his presentation with an overview of the funding opportunities that the state had submitted applications for including a State HIE Exchange Cooperative Agreement Grant where the expected award to the State is $9.3, an HIE Extension Program application that was recently submitted by CRISP, a Beacon Community Cooperative Agreement Program with a scheduled award announcement for late March and CMS funding for the development of an HIT Planning Advanced Planning Document to obtain approval to develop the State Medicaid HIT Plan. Discussion followed on the requirement in state law that the MHCC designate one or more management service organizations that will use an application service provider to host one or more EHR systems through the Internet, and the benefit to small providers to subscribe to such a system, rather than supporting their own, individual EHR. Dr. Cowdry provided more detail regarding the makeup of CRISP, specifically the collaboration among Johns Hopkins Health System, University of Maryland Medical System, MedStar Health and the Erickson Foundation as well as outreach efforts underway with various stakeholder groups. Secretary Colmers asked Dr. Cowdry to develop a one-page, high level summary of the meaningful use definition once the regulations were finalized to be shared with the Council.

Wellness & Prevention Workgroup Presentation - Frances Phillips, Deputy Secretary, Public Health Services and Drs. Prince and Regan, Office of Chronic Disease Prevention, DHMH.

Deputy Secretary Phillips began with remarks on the 2010 Legislative Session, explaining that while there were no comprehensive wellness bills under consideration, individual bills have been introduced to allow for incentives for participation in wellness programs, capital incentives for schools and physical education as well as menu labeling and trans-fat restrictions. Of the $650 million available in ARRA funding for wellness initiatives, the Department has thus far been awarded $860,000 focused on policy and environmental change as well as media outreach for tobacco cessation. Local grants for several Maryland jurisdictions are still pending.

Ms. Phillips then turned to her presentation (available on the MHQCC website) which was focused on the evaluation of the Healthiest Maryland initiative, a statewide movement to create a culture of wellness – an

environment that makes the healthiest choice an easy choice through statewide policy and environmental change. Ms. Phillips explained that Healthiest Maryland Businesses is the cornerstone of Healthiest Maryland because it is the most viable and ready for change. Healthiest Maryland relies on three steps: (1) recruitment of grasstops leaders; (2) referring those leaders to appropriate technical assistance and (3) recognizing their successes. After walking through the suggested evaluation questions, Ms. Phillips informed the Council that the external evaluation would be a mixed design, relying on pre-post evaluation and case studies, and using the Health Management Initiative Assessment as a measurement tool. The Evaluation will follow the CDC's 6-Step evaluation framework. Dr. Regan mentioned that while the evaluation would not be considered research, due to restrictions by HHS, there would be a focus on groups that are disproportionately impacted by chronic disease and racial and ethnic disparities.

Deputy Secretary Phillips then provided a summary of the short and long-term goals of the initiative. In 2010 Healthiest Maryland Businesses expects to enroll 75 businesses, employing over 50,000 employees. In 2011, the goal would be to have 50 businesses with self-reported improvement. Between 2012 and 2014 the goal would be to have 500 businesses enrolled, of which 10 businesses would have comprehensive evaluations of impact on healthcare costs, employee health and productivity. Long-term, the initiative should result in improved employee health and stabilized healthcare costs.

To aide with the recruitment of businesses the Department has contracted with a public relations firm to assist with the development of communication and outreach tools for Healthiest Maryland Businesses. Dr. Prince also asked the Council members to act as Ambassadors based on what they are currently doing, or are committed to doing and to refer businesses to the program. Healthiest Maryland Businesses is expected to launch on May 19th, National Employee Health and Fitness Day.

Council members discussed the evaluation questions and agreed that some measures are more difficult to measure than others, thus the need for case studies. Dr. Regan commented that the external evaluator would assist with the development of tools and timelines. Dr. Davis then spoke in support of looking at well known best practices that could be part of Ambassador participation. Dr. Merrill moved and the Council unanimously approved the continued implementation and May launch of Healthiest Maryland Businesses.

Patient Centered Medical Home Workgroup Presentation - Kathleen White, Johns Hopkins University School of Nursing and Ben Steffen, Maryland Health Care Commission

Since the last Council meeting Staff have been focused on legislation (SB855/HB 929) establishing the Maryland Patient Centered Medical Home (PCMH) Program. Before presenting an overview of the legislation's components (available on the MHQCC website) Mr. Steffen thanked Council staff and that of the Office of the Lt. Governor for their work on getting the legislation off the ground, and securing a large number of legislative sponsors. Dr. White provided an overview of the legislation which establishes a PCMH program consisting of a multi-carrier pilot and approved single carrier initiatives under the authority of the MHCC. 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. This Administration 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. Finally, the bill provides for an evaluation of the PCMH multi-carrier pilot.

Acknowledging that single carrier PCMH pilots are already underway and other are planned, Dr. White commented that the legislation provides a framework for carriers to continue their own PCMH programs within the scope of reasonable state oversight by proving them with exemptions from certain prohibitions in the Insurance Article if they were approved by MHCC using broadly recognized standards of a PCMH program. Mr. Steffen concluded the presentation with an update on one additional piece of legislation, House Bill 435, which requires carriers to pay a bonus amount for after-hours care and eVisits delivered independently of a

face-to-face visit. There are several amendments currently under consideration that would restrict the bonus payments to only go to primary care providers, clearly define the time meant by "after-hours", eliminate eVisits from the payment rules and to integrate after-hours/eVisit payment reform in the PCMH pilot and evaluate it as part of the PCMH pilot.

Dean Reece asked about the feedback from the Legislature on the legislation establishing the PCMH program and Mr. Steffen commented that the House hearing is on March 11th and the Senate hearing is scheduled for March 16th and that Staff are very optimistic about the likelihood of passage There is a great deal of stakeholder support. Staff are already looking ahead to the challenge of getting primary care practices that are already experiencing a great deal of stress to sign-on to participate. Dr. Koza, sitting in on behalf of Dr. Tuckson, asked about alternatives to the requirement in the legislation that would require patients to sign a consent form before carriers are permitted to share information in the PCMH program. Mr. Steffen acknowledged that carriers may view this annual consent requirement as significant but commented that the significant emphasis on patient responsibilities requires a level of commitment by patients. Secretary Colmers then moved and the Council unanimously approved a motion to continue with implementation, including the passage of the Administration legislation establishing the Maryland PCMH program.

Evidence-based Medicine Workgroup Presentation - Richard "Chip" Davis, Johns Hopkins Medicine

Dr. Davis' presentation (available on the MHQCC website) provided an implementation update of the Blood Wastage Reduction and Maryland Hospital Hand Hygiene Collaboratives. Dr. Davis walked the Council members through the various activities of the Hand Hygiene Collaborative, which have included in-person meetings, webinars, observer training, entering hand hygiene compliance data into HandStats and reporting on process measures. Seventy-five percent of the participating hospitals entered January hand hygiene compliance data into HandStats. While statewide compliance rates will be reported in the aggregate at the June Council meeting, hospitals are able to receive compliance feedback reports for their individual hospitals every month. These reports will illustrate performance by employee role and by unit. Dr. Davis commented on the value of these particular reports in allowing facilities to know which group to target, as messages will differ for each group. In addition to showing disparities between units and health care worker type, they will also facilitate the sharing of best practices. Process measures on four categories will be submitted next week: (1) leadership engagement and support aids; (2) monitoring performance and feedback system; (3) educational resources and communication campaign; and (4) environment optimization.

Dr. Davis shared preliminary plans for an evaluation study aimed to advance the science of hand hygiene and healthcare associated infections(HAIs) by linking hand hygiene compliance rates to HAIs, with an initial focus on central line associated bloodstream infections (CLABSI) in ICUs. Dr. Davis clarified that the data being entered into HandStats are observations of hand hygiene by healthcare worker upon exit of the patient environment. Ms. Berger inquired about linking hand hygiene compliance to length of stay and readmits to the ICU due to HAI. Dr. Davis responded that the evaluation has yet to be finalized but the initial goal is to see a drop in HAIs due to hand hygiene across the state.

Dr. Davis then turned to the Blood Wastage Reduction Collaborative, reminding the Council that all hospitals with operating blood banks are voluntarily participating in the collaborative and 93 percent of hospitals are submitting data on a monthly basis. Thus far the Collaborative has resulted in platelet savings of 206 units, for a savings of more than $104,500. Plasma savings have totaled 71 units, for a savings of $3,898 to the State. The Collaborative aims, by July 1, 2010 to reduce blood wastage for platelets and plasma by 1 percent which would translate to a savings of 470 units of platelets and 495 units of plasma, for a combined savings to the state of $265,481. Next steps for the Collaborative include conducting a measurement system analysis to ensure consistent data collection among collaborative participants and developing benchmark capability for reports. The workgroup is continuing to look at a website enhancement to create a "Craig's List" for short dated products that will allow blood banks to post short-dated inventory and allow facilities to access and see what is

available during emergent situations. The Red Cross is looking into the possibility of hosting this function on their website. Ms. Epke commented on the value of the Craig's List-like initiative, which would have been of great use during the heavy snow storms in February.

Dr. Davis then outlined options that the workgroup has begun to consider for future initiatives. While a specific recommendation has not yet been identified, the workgroup has considered the creation of a statewide prevention initiative to support hospital's efforts around reducing potentially preventable readmissions. Options include building upon the hand hygiene collaborative to focus on other infections or to partner with existing HAI prevention efforts around the state. Further, a letter was going out from Secretary Colmers and the Maryland Hospital Association to all hospital CEOs soliciting ideas about initiatives that the workgroup could take on. Secretary Colmers asked the workgroup to continue to narrow down the focus and to present recommendations at the June Council meeting.

Discussion of Next Steps

Secretary Colmers concluded the meeting by reminding the Council of the next meeting on June 11th. Prior to the meeting the Council will be notified of the launch of the Healthiest Maryland initiative and hopefully the bill signing for the medical home legislation. The next meeting will also include a presentation of initiatives of interest to the Council such as the work of the Maryland Patient Safety Center or the disparities work being done at the Department of Health and Mental Hygiene. The Secretary asked Council members to let Staff know if there were other topics they were interested in.

The meeting adjourned at 11:45.