Maryland Health Quality and Cost Council
Meeting Summary
Friday, May 16th, 2008
9:30 a.m. to 12:00 p.m.
Maryland Department of Transportation
Harry Hughes Suites
7201 Corporate Center Drive
Hanover, Maryland 21076

Council Members Present: Jill Berger, Jerry Boden for Lt. Governor Anthony Brown (Chair), Jerome Carr for E. Albert Reece, Debbie Chang, James Chesley, John M. Colmers (Vice-Chair), Chip Davis, Barbara Epke, Peggy O'Kane, Christine Stefanides, Reed Tuckson, Kathleen White

Absent: Thomas LaVeist, Roger Merrill

Staff Present: Alycia Steinberg

1. Welcome by Secretary Colmers and Jerry Bodin

Introductions.

2. Charge to the Council, Review of Executive Order, Discussion of Goals

Secretary Colmers summarized the charge and goals of the Council. Governor O'Malley created the Council by Executive Order, recognizing that health care reform must address quality and cost as well as access. The council's charge includes:

- Coordinating and facilitating collaboration on health care quality improvement and cost containment initiatives;
- Making recommendations on health care quality and cost containment initiatives and priorities to policy makers, State and local governmental entities, professional boards, the Maryland Patient Safety Center, industry groups, consumers, and other stakeholders;
- Developing a chronic care management plan to improve the quality and cost-effectiveness of care for individuals with, or at risk for, chronic disease;
- Facilitating the integration of health information technology in health care systems; and
- Examining and making recommendations regarding other issues relating generally to the Council's mission to improve health care quality and reduce costs in the State.

HB 1395 (2008) also requires the Maryland Department of Health and Mental Hygiene (DHMH) and the Council to study chronic care and develop a chronic care plan.

Council members noted that passage of HB 1395 by General Assembly demonstrates shared leadership by the legislative and executive branches and a shared understanding that health care reform must be about more than expanding coverage. Council members commended the leadership in Maryland for making health care a priority and for acknowledging the advancement that Maryland needs to make. It was also noted that involvement of the legislative branch in the work of the Council is important.

The scope of the Council is broad, and the Council must be judicious in selecting its initial focus.

3. States' Efforts to Improve Quality and Contain Costs

Other states are taking different approaches to improve quality and contain costs. Alycia Steinberg gave an overview of activities in Vermont, Maine, Arkansas, Massachusetts, Minnesota, and Wisconsin. There are many common themes among states, including multifaceted approaches, focus on chronic disease, payment reform, public reporting, and evidence-based guidelines. See http://dhmh.state.md.us/mhqcc/html/meeting_materials.htm for the presentation.

4. Overview of Some of Maryland's Initiatives

Alycia Steinberg gave a brief overview of some Maryland initiatives around cost and quality. See http://dhmh.state.md.us/mhqcc/html/meeting_materials.htm for the presentation. Maryland State agencies and independent commissions include the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), the DHMH Office of Health Care Quality, the DHMH Pubic Health Administration, and the Maryland Insurance Administration. HSCRC oversees Maryland's unique all-payer hospital system that sets hospital rates. MHCC has broad authority and issues public reports on a number of areas. Maryland has incredibly good health care utilization data as a result of the activities of these commissions.

The State also has an important role as payer, covering approximately 680,000 people under Medicaid, and approximately 260,000 people under state employees' benefits.

Other activities in the state include:

- Maryland Patient Safety Center, which facilitates collaboration across providers to promote learning and prevent medical errors;
- Maryland Hospital Associate Quality Indicator Project, which operates a national comparative analysis databases for health care facilities;
- CareFirst's Quality Rewards program to reward physicians who take measurable steps toward improving health care effectiveness and affordability, and support for health information technology initiatives; and
- UnitedHealth's Premium designation program that which identifies physicians who follow evidence-based guidelines, and evaluates hospitals.

A question was raised about the uninsurance rate—it is approximately 14% in Maryland, about 750,000 people.

5. Maryland Baseline

The presentation continued with information on Maryland's baseline performance. Maryland's performance on quality measures tends to be average compared to other states. Alycia Steinberg reviewed information on the population size and distribution, health care expenditures, current reporting efforts in Maryland, how Maryland compares to other states in national analyses, findings from some of the Dartmouth Atlas Project's work on geographic variation, and information on indicators of health, including racial disparities in mortality. See http://dhmh.state.md.us/mhqcc/html/meeting_materials.htm for the presentation.

Council members were interested in seeing additional kinds of information, including:

- Maryland's performance on the UnitedHealth Foundation's *America's Health Rankings*, available at http://www.unitedhealthfoundation.org/ahr2007/states/Maryland.html.
- Information on emergency room use among Medicaid enrollees.
- Health disparities data for Asian and Hispanic populations.
- Information on Maryland's trends in public health promotion expenditures.
- Background on major initiatives in Maryland, and identified priorities of other groups and commissions working on cost and quality.
- Cross-map of performance measures used in different initiatives in Maryland.
- Differences in performance by regions (including regarding support for Leapfrog).
- Differences in health and wellness data and initiatives by different populations, including children versus adults, especially around obesity prevention.
- Utilization around "hot button" areas where there might be waste in the system, such as emergency room use, imaging, and avoidable hospitalizations.
- Comparison of costs and cost drivers in Maryland versus nationally.
- Replication of Dartmouth analyses with more recent Maryland data, including analysis at the hospital level.

6. Discussion of Potential Strategies for Improving Quality and Containing Costs

Secretary Colmers led a discussion around potential strategies for improving quality and containing costs. One categorization of strategies was presented, adapted from the Institute of Medicine (IOM). See http://dhmh.state.md.us/mhqcc/html/meeting_materials.htm for the presentation. The categorization included four main strategies:

- Translate research and evidence-base into practice;
- Health promotion and disease prevention programs to target key behaviors;
- Information infrastructure to support care provision and measurement; and
- Alignment of financing structure and financial incentives with goals.

Actions for each of these strategies were identified.

Discussion among Council members noted that access to care is essential but not mentioned here. We must consider all the nuanced meanings of access—not just insurance coverage. Access, quality, and cost are three legs of a single stool, and provide a filter through which all issues must be considered. We need to focus on changing how care is delivered, for example how we pay providers. The main categories we need to address include 1) Keeping people healthy, and addressing preventable disease particularly around tobacco use, diet, and exercise; 2) Improving quality and appropriateness in health care; 3) Helping consumers make better choices about their care and wellness; and 4) Coordinating care and helping people navigate the system.

We should clarify the leverage points that the State has—for example, public education through government and schools; collaboration among public and private purchasers; social infrastructure for care coordination and support through local public agencies and private community-based organizations; networks of providers; and existing commissions and agencies. Knowing the priorities of providers, agencies, and commissions will help us be synergistic and break down silos. The Council's role is to provide overall direction for the disparate activities and priorities that currently exist.

We also need to lay out the tools that can help us achieve our goals, such as health information technology. Once we specify the tools we need to get them out to providers.

It was also noted that availability of care does not mean access. We need to consider provider reimbursement. Other key issues include patient-centered and medical home models; racial and ethnic disparities in care; high administrative costs; and focus on community-based interventions such as health education.

Collaboration among existing public and private initiatives is important. We should learn best practices from regional and local levels, and then get community-level buy-in to the larger goals or emphasis laid out by the Council.

7. Discussion of Potential Focus Areas

Secretary Colmers led a discussion around specific health topics. The framework we establish for improving quality and containing costs could be applied to specific health topics to help identify action items. The IOM priority areas are a way to begin to identify health topics. The IOM priority areas are based on impact, improvability, and inclusiveness and encompass four domains of care and cross-cutting system interventions. A chart of health conditions was distributed and is available at http://dhmh.state.md.us/mhqcc/html/meeting_materials.htm.

Council members made the following suggestions. The epidemiological rigor used by IOM to identify priority areas should be applied to Maryland to identify priorities in our state. We should align our initiatives with national trends, but still be free to address what's important in Maryland. Health disparities is an important topic, and is related to access. Healthcare-associated infection is also important. End-of-life care represents an intersection of cost and quality issues, but may be difficult to start with because of associated ethical issues.

Council members stated that it is important to address the entire system. Drilling down on specific items can help create actionable steps to achieve larger goals. For example, for a specific condition such as cardiovascular disease we could look at the full spectrum of health and health care, from population-based health promotion to end-of-life care. It is important to keep sight of system-level goals.

8. Process/Next Meeting

The Council will meet quarterly. Future meeting dates will be set well in advance to accommodate schedules as much as possible. DHMH staff will explore the possibility of holding some meetings by conference call.

Adjournment 11:40 AM
Respectfully submitted,
Laurel Havas