Maryland Health Quality and Cost Council
September 24, 2010
9:30 a.m. – Noon
UMBC Technology Center

Meeting Minutes

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

Members absent: Lt. Governor Brown, Debbie Chang and Thomas LaVeist

Staff: Nicole Stallings, 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. Secretary Colmers informed the Council that the Lt. Governor sent his regrets for being unable to attend the meeting and shared his appreciated for their continued participation. The June 11, 2010 meeting minutes were approved.

Updates

Secretary Colmers provided the Council with an update on the Maryland Health Care Reform Coordinating Council's activities regarding health reform implementation and the work of the six workgroups: Health Insurance Exchange and Insurance Markets, Entry to Coverage, Outreach and education, Public Health, Safety Net and Special Populations, Health Care Workforce and the Health Care Delivery System. Secretary Colmers commented that the State needs to work on bending the cost curve and that the work of the Quality and Cost Council is more important that ever. Recent activities at DHMH included: MHIP Federal launched; several insurance protections went into effect yesterday, approved for funding for Rate Review, Infant And Early Childhood Home Visitation Program, public health infrastructure, workforce development and awaiting notification on other opportunities. Several Council members expressed their support for streamlining eligibility and enrollment and the importance for health workforce initiatives to address the primary care gap. Secretary Colmers commented that draft recommendations of the Council would be presented at the December meeting.

Presentation: Statewide Reporting of CLABSI data—Pamela Barclay, Director, Center for Hospital Services, MHCC

Secretary Colmers reminded the Council that Central Line –Associated Blood Stream Infection (CLABSI) data are not what they should be. The only acceptable rate of CLABSI, or any HAI for that mater, is zero. Both the Evidence Based Medicine Workgroup and various agencies of DHMH work to eradicate HAIs. One approach which is undertaken by the Maryland Health Care Commission is public reporting of infection rates.

Pam Barclay's presentation (available on the MHQCC website) illustrated the MHCC's work towards the public reporting of hospital-specific CLABSI data in adult and pediatric intensive care units (ICUs) and Level II/III and III neonatal intensive care units (NICUs) were reported in October, 2010 on he 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. Before release of the CLABSI data on the Guide, the MHCC and its HAI Advisory Committee conducted a series of focus groups on the way in which the data are reported to ensure that complicated infection rates are presented in a consumer-friendly way that makes it easier to understand.

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.

Council members discussed the concerning numbers and the activities that are occurring at across the state to look at benchmarks and improve these numbers. Barbara Epke then talked about the On the CUSP: Stop BSI patient safety initiative being championed by the Maryland Hospital Association. This program is a comprehensive unit-based safety program funded by AHRQ. Currently, 41 out of 46 hospitals signed on to participate, including three specialty hospitals. Ms. Epke will keep the Council apprised of progress in this program.

The Secretary concluded that the focus on public reporting can help facilities know where they stand comparing to their peers, and help them think about what they can do to improve from status quo.

Presentation: Patient Centered Medical Home Workgroup—Kathleen White, Johns Hopkins University School of Nursing and Karen Rezabek, MHCC.

Dr. White's presentation (available on the MHQCC website) provided updates on seven meetings held across the State over the summer and were attended by over 600 providers. Over 160 practices and/or practice locations have expressed interest in participating. While some practices applied for most/all of their practice locations there were no "expressions of interest" from three counties: Somerset, Caroline and Kent. Further, interest from practices in Washington County was less than expected. Ms. White then discussed the selection criteria for

practices which include their commitment to the principles of the PCMH model, their diversity in size, location and the practices they serve, and commitment to reach NCQA Level 1 or better recognition. Planning for practice transformation is underway through funding from the Community Health Resources Commission. Council members discussed the payment methodology and asked for additional detail at the next meeting.

Karen Rezabek then discussed the outreach to purchasers and employers that was underway. Staff are currently working with the Maryland State Health Benefit Plan and other large employers to commit to participate in the plan. Efforts to encourage other large employers to participate will increase in October. Jill Berger stressed the importance to have a communication plan to give to employers for them to understand PCMH and offered to help in this process.

The Selection Committee is expected to identify participating practices in October and to launch the program in January once practices and carriers sign participation agreements. Barbara Epke raised concerns about the practices that expressed interest in participating and are not chosen and asked if there was an option to expand beyond 50 practices. Staff replied that the goal is 200,000 patients, and that number may be achieved by more or less practices, depending on their size. There was clarifying discussion about outreach to carriers and employers. Ms. Stallings explained that while the enabling legislation did require that all large carriers participate in the multi-payer pilot, it cannot dictate what self-insured businesses do, as the State does not have jurisdiction over the plans offered in most large businesses in the state. Staff continue to work with the State's largest employers, including Purdue and Marriott.

Secretary Colmers notes that it is important to think about the future role of the workgroup with respect to the Council and asked that the workgroup present a recommendation at the December Council meeting. Secretary Colmers then moved and the Council unanimously approved a motion to continue with statewide implementation efforts.

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

Dr. Davis' presentation (available on the MHQCC website) began with an update of the Blood Wastage Reduction Collaborative which was on a trend line to save more than the 1 percent goal before the February 2010 blizzards. The blizzards 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 592 combined units for a savings of $203,109 thus far. 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 "Craig's List" concept is now formally called the Inventory Visibility System, on which short-dated products are listed so that other hospitals can use them. This system will be piloted in Baltimore areas hospitals in November before going statewide in December, 2010 and has already received attention from the National Red Cross President of Biomedical Sciences.

The Maryland Hospital Hand Hygiene Collaborative continues to move forward. At 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 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.

Dr. Davis then discussed future initiatives of the workgroup, reminding the Council that they 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 will be held in October and the workgroup will update the Council on this recommendation's implementation at the December meeting.

Dr. Davis then invited Drs. Eric Aldrich and Barney Stern, neurologists from Johns Hopkins and University of Maryland, respectively. Drs Aldrch and Stern were asked to co-chair the Telemedicine Task Force which was asked to develop the business case for a statewide Telemedicine Network. Members of the Task Force 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. 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 group recommends that 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. Secretary Colmers thanked Drs. Aldrich and Stern and the Task Force members for their hard work over a short amount of time. He then encouraged that the Task Force reach out to additional stakeholders, including payers and community hospitals and further refine the recommendations for the December Council meeting

Secretary Colmers then made a motion and the Council unanimously approved for the continued development of the telemedicine and regulated medical waste initiatives and continued implementation of the hand hygiene and blood wastage collaboratives.

Presentation: Wellness and Prevention Workgroup—Frances Philips, Deputy Secretary, Public Health Services,

Deputy Secretary Phillip's presentation (available on the MHQCC website) reminded the Council that 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. The Healthiest Maryland Businesses process begins with recruitment, then referrals are made to resources for evidence-based worksite wellness programs– including those accredited by NCQA, URAC, and resources from the CDC and the voluntary health agencies such as the American Heart Association and the American Cancer Society--then participants are recognized for their commitment to a healthier workforce.

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 91 businesses committed as of September 2010. Well attended launches were held in Baltimore, Salisbury, and Rockville, and a launch is forthcoming in Cumberland, Maryland. Looking forward, it is projected that close to 125 business will be participating during the third quarter.

The presentation then provided an early analysis on the types of businesses that are enrolled and the employees that are covered in the program. Among the current participating Healthiest Maryland businesses, the industry types most represented are health care and social assistance, finance and insurance, professional/scientific/technical services, and other services- except public administration. The occupation distribution was analyzed by industry and race. When considering the total number of Black or African American 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. It is also noteworthy to mention that industries employing women are well represented. Within the healthcare and social assistance industry, 78.4% of the workforce is women, as well as the finance and insurance industry, where 60.0% of the workforce are women.

Through the Healthiest Maryland Businesses evaluation, which is being led by Health Economist, Dr. Judy Shingle at UMBC, there will be an assessment of changes in health outcomes by race. Ms. Phillips commented that many of the changes to take place within the businesses will be policy and environmental changes that have the potential to impact all employees and their families. However, assessing health outcomes data to determine impact is imperative. At the December Council meeting Ms. Phillips will provide an update of the Healthiest Maryland Businesses evaluation plan. Secretary Colmers then moved and the Council unanimously approved the continued implementation of Healthiest Maryland.

Discussion of Next Steps

Nicole Stallings walked the Council members through the draft Annual Report, which is to be submitted to the Governor and General Assembly by January 1, 2011. Ms. Stallings commented that the report will include two new sections, one on health disparities and the other on health reform and opportunities for coordinating with the Health Care Reform Coordinating Council. Ms. Stallings asked all Council members to send her comments on this draft. Another version would be submitted for their review around the Thanksgiving Holiday and the final report would be approved at the December meeting.

Secretary Colmers concluded the meeting reminding Council members that the December meeting would include the standing agenda item of an update on health reform implementation as well as implementation updates from each workgroup.

The meeting adjourned at 12:06.