Maryland Health Quality and Cost Council
Wellness and Prevention Workgroup
(formerly Chronic Care Workgroup)
Meeting Summary

January 30, 2009

3:00-4:00 EST

Purpose

Establish the direction and processes for identifying priorities for the Chronic Care Management Plan: Wellness and Prevention Work Group through data sharing and discussion

Discussion Summary

To more clearly identify the scope of the Workgroup, the Workgroup will be renamed the "Wellness and Prevention" Workgroup and will address chronic conditions at the earliest stages.

The Workgroup concurred with goals, objectives, tasks, procedures, and roles as amended in the Charter (Attachment A) and Workplan and Timeline Overview (Attachment B).

The Workgroup adopted the Methodology for Priority-Setting (Attachment C) which identifies high-priority conditions based on clinical, social, and economic **burden** and determines the **improvability** of outcomes for that condition. Last, a "**gut check**" is performed to ensure that this makes sense given political and social will and existing partnerships.

The Workgroup quickly agreed with the identification of diabetes and childhood obesity as initial priority conditions to be addressed by the Wellness and Prevention Workgroup's proposed strategies for the Chronic Care Management Plan.

The Workgroup identified criteria to be used for identifying strategies. The scope of strategies is broad, including policies and community-based practices. (Clinic-based practices will be coordinated by Primary Care Workgroup.) The next step is identifying strategies for promoting healthy eating and physical activity, assuring early detection and linkage to treatment, and engaging Marylanders to be proactive in preventing and controlling their chronic conditions.

Teleconference Participants

Council Members: John Colmers, Jill Berger, Roger Merrill, Peggy O'Kane, Reed Tuckson

Other Participants: Allison Gertel-Rosenberg (representing council member Debbie Chang), Adam Milam (representing Delegate Tarrant), Amy Deutschenberg (Johns Hopkins), Lori Doyle (Community Behavioral Health Association), Carmela Jones (representing Maryland Hospital Association), Alan Lake (Maryland chapter of American Academy of Pediatrics), Amjad Riar (Capitol Palliative Care Consultants), Magaly Rodriguez deBittner (University of Maryland School of Pharmacy), Nancy Witkowski (Boehringer Ingelheim Pharmaceuticals)

Staff: Frances Phillips (Secretary's designee), Audrey Regan, Maria Prince, Susan Milner, Orion Courtin, Mary Mussman

Next meeting: Teleconference on March 2, 4-5 pm, EST

ATTACHMENT A

Maryland Health Quality and Cost Council
Wellness and Prevention Workgroup
Charter
January 30, 2009

Goal, Objective, and Tasks

The goal of this Workgroup is to focus on identifying actionable wellness and prevention strategies that fulfill the Maryland Health Quality and Cost Council's charge "to provide the leadership, innovation, and coordination necessary to improve the quality of health care provided to Maryland citizens, to address the escalating costs of health care, and to encourage advancements in wellness, prevention and chronic care management toward the overarching goal of a healthier State." (Governor's Executive Order, October 2007)

The objective of this Workgroup is to draft the wellness and prevention plan components by September 1, 2009 to coordinate with the development of Maryland's comprehensive strategic chronic disease prevention and care plan by December 1, 2009.

The Wellness and Prevention Workgroup is 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;
- Addressing proposed legislation and regulatory changes necessary to accomplish proposed strategies; and
- Determining workgroup activities necessary to monitor execution of the strategic plan in 2010 and beyond.

As part of its deliberations when selecting and elaborating on strategies, each workgroup will consider ways to ameliorate disparities and expand the use of health information technology. In addition, each workgroup will also thoroughly consider the effect of its proposed strategies on stakeholder groups, such as payers, providers, and patients or consumers, before presenting ideas to the full Council.

Members

Workgroup members include self-selected Maryland Health Quality and Cost Council Members. Representatives from existing chronic disease prevention and care advisory committees and other interested parties will be invited to participate in the Workgroup.

Workgroup Member	Affiliation	Council
Fran Phillips (chair)	DHMH	Secretary's designee

Jill A. Berger, MAS	Marriott International	MHQCC
Debbie Chang, MPH	Nemours Health & Prevention Service	MHQCC
James Chesley, Jr, MD	Practicing Physician/Med Chi	MHQCC
Roger Merrill, MD	Perdue Farms Incorporated	MHQCC
Peggy O'Kane, MHS	National Committee for Quality Assurance	MHQCC
Al Reece, MD,PhD,MBA	Univ of Maryland School of Medicine	MHQCC
Reed Tuckson, MD	United Health	MHQCC

Operating Procedures and Roles

Workgroup members will convene on a regular basis until November 1, 2009 with the frequency to be determined by the Chairperson to address the scope and timeline for deliverables.

Workgroup procedures follow those of the Maryland Health Quality and Cost Council.

- A majority of the Council membership on the Workgroup is a quorum.
- The Workgroup may act upon any matter with the authorization of a majority of the quorum present and voting.
- A member of the Workgroup may not receive compensation, but is entitled to reimbursement for expenses under the Standard State Travel Regulations as provided in the State budget.
- The Secretary shall designate the staff necessary to provide support for the Workgroup.

Pursuant with State law, meetings will be advertised and open to the public. Information will be shared via the Web Site and a small list serve of interested parties. There will be an opportunity for noncouncil members to provide input at the end of the Council Discussion.

Chairperson is expected to

- Plan and lead all Workgroup meetings
- Ensure timely completion of Workgroup products and deliverables

Workgroups members are expected to

- Participate actively and constructively in all Workgroup meetings
- Respond to email notifications and solicitations in a timely manner
- Be prepared to contribute to work group deliberations by reviewing all documents and materials distributed in advance

Lead staff are expected to:

- Support the Workgroup chairperson and members in conducting Workgroup business
- Provide background materials and documents for deliberations at each monthly meeting at least 4 days before the meeting
- Solicit other experts to participate in Workgroup meetings to inform specific discussions by the Workgroup

ATTACHMENT B

Maryland Health Quality and Cost Council
Wellness and Prevention Workgroup
Workplan and Timeline Overview
January 30, 2009

Task	Actions	Lead Staff	2009 Date
Establish Processes and Identify Focus areas	Provide general feedback on direction for Workgroup	MP	Jan
	Draft: Charter, Workplan and Timeline	MP	Jan
	Draft: Proposed methodology for priority-setting	MP	Jan
	Brief: Case Example of Diabetes and Childhood Obesity	MP	Jan
	Review staff-prepared background materials on Workgroup Processes, Priority-setting strategy, and Potential focus areas(Workgroup)	FP	1/30
	Minutes: Priorities for Maryland	MP	2/3
Identify Wellness and Prevention Strategies	Brief: Proposed methodology for selecting Wellness & Prevention strategies	MP	Feb
	Provide feedback for Wellness and Prevention scan	MP	Feb
	Draft: Preliminary Wellness and Prevention strategies	MP	2/23
	Review and prioritize Preliminary Wellness and Prevention Strategies (Workgroup)	FP	3/2
	Minutes and Draft: Wellness and Prevention Strategies	MP	3/10
	Share Workgroup goals, focus areas, and Wellness and Prevention strategies (Full Council)	FP	3/20
	Provide feedback for strategies to be included in strategic plan to be presented at June Meeting	MP	Apr/ May
	Brief: Wellness and Prevention Strategies	MP	May
	Discuss and approve proposed strategies (Workgroup)	MP	June
	Discuss and approve proposed strategies (Full Council)	FP	6/10
Articulate Strategies' Requirements	Provide feedback for priorities, measures, timelines, estimated costs, estimated health benefits, proposed legislation or regulatory changes, and implementation partners associated with each strategy	MP	July
	Finalize strategies (Workgroup)	MP	July
Write and Coordinate Plan Process	Coordinate Plan writing with other Workgroups	MP	Sep
	Review Proposed Chronic Care Management Plan Wellness and Prevention Components (Workgroup and Full Council)	FP	Sep
	Edit Plan	MP	11/1

ATTACHMENT C

Maryland Health Quality and Cost Council
Wellness and Prevention Workgroup
Methodology for Priority-Setting
January 30, 2009

Summary: B.I.G. is an acronym describing a priority-setting strategy that uses data to identify high-priority conditions based on clinical, social, and economic **"Burden"** and to determine the **"Improvability"** of outcomes for high-priority conditions. A **"Gut check"** is also performed to ensure that establishing this priority makes sense.

Step 1: Identify high-priority conditions based on current clinical, social, and economic **burden** (i.e., health conditions that affect the most people (particularly socially disadvantaged people), most severely, and at the greatest cost to Maryland including the state government, employers, and our health care system). Increasing burden and predicted increases in burden are also important considerations.

Suggestion: Start with priority areas identified by other methods (Institute of Medicine Priority Areas for National Action, Healthy People 2010 Leading Indicators)

Step 2: For these high-priority conditions, identify potential for **improvability** (i.e., large preventable burden of disease; technical feasibility or availability of evidence-based strategies for improvement through promoting wellness and early identification and treatment of disease; large, measurable gaps in prevention and care compared to evidence-based standards; and relatively low current resource allocation).

Step 3: Last, apply the **gut check** (i.e., this makes sense; political and social will exists to address the priority; partnerships are established to tackle this priority).