

Maryland Health Quality and Cost Council
Friday, September 5, 2008
1-3:30 PM
Maryland Dept. of Transportation
Meeting Minutes

Council Members Present: Secretary Colmers, Lt. Governor Anthony Brown, Debbie Chang, James Chesley, Chip Davis, Barbara Epke, Thomas LaVeist, Roger Merrill, Peggy O’Kane, Albert Reece, Christine Stefanides, Kathleen White

Absent: Jill Berger, Reed Tuckson

Staff Present: Lydia Isaac

1. Intro and welcome from Lt. Governor Anthony G. Brown
2. Approval of minutes
3. Review and comment on staff draft of mission and vision statement for Council (see attachment for options)

Four alternatives of a vision statement were suggested to Council for consideration. Various terms in each were acknowledged as attractive including the concept of being a leader among states, cost containment, the inclusion of IOM terms from option 4 (adapted from the Massachusetts model). There were mixed opinions on whether to include the concept of ranking. The Secretary suggested that Option #1 be used, amending it to say that MD is a “demonstrated leader,” and then add the rest of the language from option 4 which includes the IOM criteria of care which is safe, effective, patient-centered, timely efficient, equitable, integrated, and affordable.

Three alternatives of a mission statement were suggested to the Council for consideration. Council members suggested that the development of strategic plan which provides units of measurement for what it is accomplished, in conjunction with a mission statement, might be useful. Specifically, option 3 provides important specifics which should be included in a strategic plan if not in mission statement. Number 1 appears to incorporate the essential items of number 2, and number 3 is perhaps too specific and thus not encompassing enough. Including the evaluation component is essential. Council consensus is to go with option 1 with some changes; Lt. Gov notes that overseeing the implementation and evaluation of initiatives may be overstating our charge. “Oversee” concluded as too strong a word in number one, so will use the word “monitor” instead.

4. Review and comment of proposed Work Plan for Council

Council reviewed proposed Work Plan which outlines a time-line for the accomplishment of certain activities and objectives of the Council. Work Plan includes an Environmental

Assessment (inventory public and private sector initiatives, best practices from other states), Establishment of Objectives (adoption of mission and vision, goals identification, creation of work groups, develop strategies for a Chronic Care Plan), and Determine implementation activities and monitoring.

5. Inventory of public sector initiatives currently being used in Maryland

a. Wendy Kronmiller, Director of Office of Health Care Quality (OHQC)

The OHQC is charged with monitoring the quality of care in Maryland's health care and community residential programs. This is accomplished mainly through regulation and enforcement; the Office's regulation purview includes ambulatory care, assisted living programs, mental health programs, hospitals, HMOs, laboratories, long term care, community based programs for the developmentally disabled, and substance abuse treatment centers. The Office enforces State and Federal regulations which set minimum standards for the provision of care, and also educates providers and consumers. New paradigms are being created as there has been a shift to community models of care, changes in how care is provided; these changes are positive but present a challenge to government.

b. John Folkemer, Deputy Secretary, Health Care Financing (Medicaid)

Historically Medicaid has not been focused on quality; currently seven major components of today's quality initiatives which include MCO Systems Performance Review, Healthy Kids Quality Monitoring Program, Enrollee Satisfaction Surveys, Healthcare Effectiveness Data and Information Set (HEDIS), Value Based Purchasing, Consumer Report Care, and Performance Improvement Projects (currently Improving Screening for Chronic Kidney Disease and Improving Cervical Cancer Screening). Future projects include non-payment for hospital adverse events and Nursing Home Pay for Performance Quality Initiatives. Challenges include finding meaningful and attainable performance measures that can be applied to all MCOs, getting funding for incentives, and developing a methodology to measure performance or care obtained by the population that is excluded from the HEDIS methodology.

c. Steve Ports, Principal Deputy Director, Health Service Cost Review Commission

Mr. Ports presented an update on the current status of the HSCRC's Quality-Based Reimbursement Initiative. A steering committee was created in 2003 and its final recommendations were approved in June 2008. Nineteen process measures were selected to be scored, in consistence with those reported on the MHCC Performance Guide and CMS/Joint Commission Core Measures. An assessment and scoring model was developed, and in FY 2010 the scoring method will be transferred into

payment. The precise amount will be finalized later but is projected to be approximately \$60 million. An evaluation workgroup was also established to evaluate the Initiative. It was acknowledged that looking at outcome measures can be misleading since the easiest way to improve outcomes to do procedures on healthy people.

d. Dr. Carlessia Hussien, Director, Office of Minority Health and Health Disparities

The Office's goal is to reduce and begin to eliminate minority health disparities in Maryland. Dr. Hussien presented an overview of three initiatives, the first of which was DHMH Department Assessment — Systems Change. Given MD's significant minority health disparities, and that those disparities generate unnecessary health care costs, this project attempts to conduct an assessment of the status of each disparity, develop and publish a plan of action to increase the pace of reducing disparities, and implement focused plans that target the reduction of minority health disparities. Currently, an oversight Task Force has been developed, three demonstration projects are on-going, and 15 technical assistance meetings have occurred within DHMH. An additional initiative, the Workforce Diversity and Cultural Competency program, has as its goal to improve patient-provider communication when minorities interact with the health care system, and to increase health literacy among patient populations, improving adherence to treatment. Currently a study has been piloted, and the Office is assisting three community hospitals. The third initiative is the Health Data project, which aims to improve the availability of data by race and ethnicity and produce meaningful analysis to identify disparities, track root causes, and monitor progress. The Office publishes data periodically and has provided data assistance to programs within DHMH.

e. Arlene Stephenson, Deputy Secretary for Public Health Services.

Ms. Stephenson described various public health quality initiatives occurring within the DHMH, including the Maryland Health Care Workers Influenza Institute which trains partners to administer vaccines, the Infection Control Education and Consultation program provided to all acute hospitals and LTC facilities, Community-based quality initiatives for individuals with developmental disabilities which includes care coordination and medication administration, dysphagia management in Disabilities Administration facilities to reduce the risk of choking, aspiration and related conditions, and the Healthy Lifestyles for People with Disabilities program which provides holistic wellness workshops followed by support groups.

Dr. Maria Prince, Office of Chronic Disease Prevention, then described the quality initiatives occurring within this Office, one of the Public Health Services offices within the DHMH. This newly created office deals with obesity, chronic conditions

such as hypertension and diabetes, and complications such as heart failure and stroke. Current efforts include disease incidence and prevalence assessment from BRFSS data, health care utilization assessment from HSCRC data, and mortality assessment from Vital Statistics data. The Chronic Care model was highlighted, as was Maryland's P3 Program. The P3 model (Patients, Pharmacists, and Partnerships) is improving patient satisfaction, quality of care, and achieving cost savings. The Office is also making efforts to improve community systems and develop strategic planning efforts, especially as they relate to childhood obesity (currently the largest data gap). It was noted that diabetes control and prevention was perhaps a topic for a Council workgroup.

f. William F. Minogue, Executive Director, Maryland Health Care Commission.

Mr. Minogue outlined Maryland's three-pronged patient safety strategy, which includes mandatory reporting, provider education and volunteer reporting, and use of data systems. The center's purpose is to provide education and training, research, adverse event reporting, and enhanced collaboratives. Key results include ICU and ED collaboratives resulting in lives and money saved. The continued challenge is that poor quality on the front end of care leads to higher costs, access to care problems, low morale of workers, unreliable care, and ultimately poor quality outcomes. The task is to introduce new values that change the mind of medicine and define a patient safety culture. These values include putting the patient first, rigorous accountability, reduce waste, decrease time waiting, and defect-free medicine.

g. Rex Cowdry, Executive Director, Maryland Health Care Commission (MHCC)

The goal of the MHCC is to aid in improving quality, outcomes, and value through information gathering and reporting, health planning and regulation, and health policy analysis. One area of focus is health care reform, a key aspect of which is controlling health care costs. Unless a more value driven health care system can be driven towards, the system is in deep trouble; even though it can be easier to talk about quality, the focus must be kept on cost control. Other MHCC areas of focus aim at improving quality, outcomes and value and include public reporting, analyses of the physician service market, working with the Office of Minority Health and Health Disparities to enhance quality measures, rebuilding Maryland's hospital infrastructure, various planning issues regarding urban hospitals, ED crowding, psychiatric care, and health information technology (including a task force on electronic health records and collaborations with HSCRC, MCHRC, and DHMH). The greatest conceptual challenge is grappling with driving value—universal coverage will require better solutions to the question of value. The MHCC works to identify high value health care, develop appropriate models to deliver high value health care, and communicates the issues to the public and professionals. MHCC also

regulates the small group market which can be used as a laboratory for delivery of high value health care. Council members pointed out that you can have higher quality along with lower costs. Enhanced quality does not mean enhanced costs, and in fact often lowers costs.

6. Initial review and discussion of Maryland's performance on IOM targeted areas—deferred until next meeting due to time constraints.
7. Next steps. In future meetings there will be less information and more discussion, but it was important to establish the base-line of what Maryland is doing. In the interim, discussions will begin about organizing workgroups. Next meeting December 12, 2008.

Respectfully submitted,
Laurel Havas