STATE OF MARYLAND
OFFICE OF THE LT. GOVERNOR

ANTHONY G. BROWN
LT. GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1925
(410) 974-2804
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

January 3, 2013

The Honorable Martin O'Malley
Governor of Maryland
State House
100 State Circle
Annapolis, MD 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House
100 State Circle, H-107
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House of Delegates
State House
100 State Circle, H-101
Annapolis, MD 21401-1991

Dear Governor O'Malley, President Miller, and Speaker Busch:

Pursuant to Executive Order 01.01.2011.09, we are pleased to submit to you a report detailing the progress of the Maryland Health Quality and Cost Council in 2012.

The Council is tasked with providing the leadership, innovation, and coordination of multiple stakeholders within our health system—payers, institutional providers, physicians, government, patients, and citizens—in an effort to improve the health of Maryland's citizens, maximize the quality of health care services, and contain health care costs.

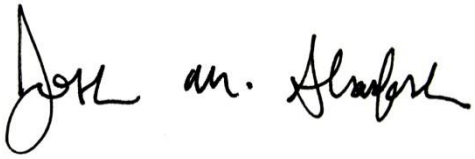
During the past year, the Council's workgroups have made significant progress in implementing key strategies to improve health in Maryland. In addition, each workgroup has been charged with incorporating strategies to address health disparities into every initiative. This report summarizes the Council's activities in 2012 and articulates a roadmap and timeline for ongoing activity.

In 2013 the Council will continue to sustain successful initiatives while championing new areas of focus aimed at addressing the prevalence of heart disease, encouraging Marylanders to use high quality health services by lowering out-of-pocket costs, and leveraging the many opportunities provided by federal health reform.

We appreciate your continued support of the Council's activities. Should you have questions, please contact Russ Montgomery, Director of the Maryland Health Quality and Cost Council at 410-767-3173.

Sincerely,

Anthony G. Brown
Lieutenant Governor
Chair, Maryland Health Quality and Cost Council



Joshua M. Sharfstein, M.D.
Secretary, Department of Health and Mental Hygiene
Vice-chair, Maryland Health Quality and Cost Council

Enclosure

CC: Russ Montgomery
Ben Stutz
Patrick Dooley
Laura Herrera
Mary Mussman
Maria Prince
Donald Shell
Ben Steffen
Sarah Albert

MARYLAND HEALTH QUALITY & COST COUNCIL

ANNUAL REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

January 2013

The Honorable Anthony G. Brown
Lieutenant Governor

Joshua M. Sharfstein, MD
Secretary, Department of Health and Mental Hygiene

MARYLAND HEALTH QUALITY AND COST COUNCIL

Chair: Anthony G. Brown, Lieutenant Governor, State of Maryland
Vice Chair: Joshua M. Sharfstein, M.D., Secretary, Department of Health and Mental Hygiene

Appointees

Jill A. Berger, M.A.S.
Vice President, Health and Welfare Plans, Marriott International

James S. Chesley, Jr., M.D.
Practicing Gastroenterologist

Lisa A. Cooper, M.D., M.P.H., F.A.C.P.
Professor of Medicine, Johns Hopkins University School of Medicine
Director, Johns Hopkins Center to Eliminate Cardiovascular Disparities

Richard "Chip" Davis, Ph.D.
President, Sibley Memorial Hospital

Barbara Epke, M.P.H., M.S.W., M.A.
Vice President, LifeBridge Health System

Roger Merrill, M.D.
Chief Medical Officer, Perdue Farms Incorporated

Peggy O'Kane, M.H.S.
President, National Committee for Quality Assurance (NCQA)

Marcos Pesquera, R.Ph., M.P.H.
Executive Director, Center on Health Disparities, Adventist HealthCare, Inc.

E. Albert Reece, M.D., Ph.D., M.B.A.
Vice President for Medical Affairs, University of Maryland
Dean, University of Maryland School of Medicine

Jon Shematek, M.D.
Senior Vice President and Chief Medical Officer
CareFirst BlueCross BlueShield

Kathleen White, Ph.D., R.N., C.N.A.A., B.C.
Associate Professor, Johns Hopkins University School of Nursing (JHSON)
Director of the Master of Science in Nursing Program, JHSON

Christine R. Wray, F.A.C.H.E.
President, MedStar St. Mary's Hospital and Senior Vice President, MedStar Health, Inc.

Staff

Russ Montgomery, M.H.S.
Director, Maryland Health Quality and Cost Council
Department of Health and Mental Hygiene

Laura Herrera, M.D., M.P.H.
Deputy Secretary for Public Health Services
Department of Health and Mental Hygiene

Carlessia Hussein, R.N., Dr.P.H.
Director, Office of Minority Health and Health Disparities
Department of Health and Mental Hygiene

Katie M. Jones, M.S.W
Health Policy Analyst, Office of Chronic Disease Prevention
Department of Health and Mental Hygiene

Mary Mussman, M.D., M.P.H.
Physician Advisor, Office of the Deputy Secretary for Health Care Financing
Department of Health and Mental Hygiene

Frances Phillips, R.N., M.H.A.
Deputy Secretary for Public Health Services (former)
Department of Health and Mental Hygiene

Maria Prince, M.D., M.P.H.
Medical Director, Office of Chronic Disease Prevention
Department of Health and Mental Hygiene

Ben Steffen
Executive Director
Maryland Health Care Commission

Grace Zaczek
Interim Director (former), Maryland Health Quality and Cost Council
Department of Health and Mental Hygiene

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EXECUTIVE SUMMARY

The Maryland Health Quality and Cost Council (Council), established by an executive order form Governor O'Malley in 2007, is tasked with providing the leadership, innovation, and coordination of multiple stakeholders within our health system—payers, institutional providers, physicians, government, patients, and citizens—in an effort to improve the health of Marylanders, maximize the quality of health care services, and contain health care costs. Over the past five years, the Council has implemented numerous initiatives that are saving lives, improving quality and reducing health care costs. The Council is working to harness these strengths and make Maryland one of the healthiest states in the nation.

During the past year, the Council's workgroups have made significant progress in implementing key strategies to improve health care in Maryland. These efforts continue to complement the ongoing process to implement the Affordable Care Act in Maryland.

Health Disparities. In late 2011, the Health Disparities workgroup, under the leadership of Dr. Albert E. Reece, Dean of the University of Maryland School of Medicine, released a final report laying out its strategy for reducing health disparities and meeting the workgroup's charge. A major part of the final report focused on the development of Health Enterprise Zones (HEZs). HEZs were defined as areas with high health disparities, fewer health resources, and a high portion of low-income and uninsured individuals. The bill contained several possible incentives that can be utilized to address disparities within the HEZ including loan assistance repayment, income tax credits, priority to enter the Maryland Patient Centered Medical Home Program, grant funding from Community Health Resources Commission (CHRC), and priority for receiving funds for establishing an electronic health records program.

Lt. Governor Brown championed HEZs and led efforts to pass legislation authorizing their creation. In early 2012, the General Assembly passed Senate Bill 234, which established a process to designate HEZs. The FY 2013 budget allocated $4 million to the Community Health Resources Commission to fund the HEZs.

To become an HEZ, a non-profit community-based organization or local health department had to apply to DHMH and CHRC with a comprehensive plan to address disparities in a defined geographic area. A set of criteria for selection were released, and the public had the opportunity to review and comment on these criteria. DHMH and the CHRC released the HEZ call for proposals in October, and 19 proposals were received by the November 15 deadline. The CHRC and evaluate the HEZ proposals and issue recommendations to the DHMH Secretary, who will make final HEZ designations.

Wellness and Prevention. The Wellness and Prevention workgroup made substantial progress in fulfilling its mission of developing actionable wellness and prevention strategies to achieve the goal of a Healthiest Maryland. Healthiest Maryland is a grasstops social marketing campaign that encourages leaders to promote wellness. Healthiest

Maryland Businesses (HMB) initiative was launched as the cornerstone of the Healthiest Maryland campaign in 2010. Since then, over 175 companies have enrolled, representing 200,000 Maryland employees and covering 22 Maryland jurisdictions. Technical assistance on best practices is provided to these companies through direct consultation by certified worksite wellness specialists, regional events, , and other initiatives. In addition, the workgroup continues to develop efforts to promote procurement of healthier food items by state agencies and participate in the WellnessStat program.

The workgroup also continues to lead the Million Hearts™ Initiative, which aims to prevent one million heart attacks and strokes in the United States over the next 5 years by emphasizing the ABCS—Aspirin for those at risk, Blood pressure control, Cholesterol management, and Smoking cessation. A Million Hearts Action Plan, passed in 2012, is a framework that the Council will use when identifying and prioritizing on-going Council activities.

Cultural and Linguistic Competency. The law signed by Governor O'Malley establishing HEZs also called for the creation of the Cultural and Linguistic Competency workgroup. This group is tasked with assessing the feasibility of and developing recommendations for multicultural health care equity in the Patient Centered Medical Home program and recommending criteria for health care providers to receive continuing education in multicultural health.

Council members Lisa Cooper and Marcus Pesquera were appointed as Co-Chairs in September 2012. After a nominations process, forty-nine persons were appointed by the Secretary to serve on the workgroup. The first meeting of the workgroup was held in November. Members were asked to submit input on a work plan and to identify areas interest. Representatives from disparities research centers and interested professionals will assist the state staff to provide support to the workgroup.

Evidence-Based Medicine. The Evidence-Based Medicine (EBM) workgroup is charged with prioritizing the widespread implementation of a discrete set of practices that have been shown to improve health care quality, decrease cost and could be instituted on a large scale relatively quickly. In 2012, Peggy O'Kane, President of NCQA, was named the new chair of the Evidence-Based Medicine workgroup.

In late 2012, the EBM workgroup began pursuing value-based insurance design (VBID) as a new strategy for promoting improved quality and health outcomes while keeping the costs of health plans low. VBID incentivizes health plan enrollees to utilize high-value health services by adjusting cost-sharing. Efforts to implement VBID in various health plans in Maryland will be the primary focus of the workgroup moving into 2013.

The Maryland Hospital Hand Hygiene Collaborative, another EBM initiative, began in 2010 with the goal of reducing preventable infections through better hand hygiene. These efforts are aligned with an initiative to track and reduce health care acquired infections (HAIs). IN 2012, there was a 39 percent reduction in central line-associated blood stream infections (CLABSIs), one of the most common HAIs.

Finally, recommendations made in 2011 by the Telemedicine Task Force were implemented in 2012. Governor O'Malley signed a law requiring private payers to cover telemedicine services, and the state has made progress in establishing an interoperable telemedicine network. The task force is currently developing a telemedicine technology implementation resource guide for providers and other entities. The group is also working to identify a range of best practices for telemedicine and release them to providers and other relevant groups.

Patient Centered Medical Home. The Patient Centered Medical Home Program was adopted as an initiative by the Council in 2009, and legislation enacted by the General Assembly in 2010. By 2012, as a result of a state-wide recruitment effort, 53 practices reflecting a broad range of practice sizes, structures and geographic locations were selected in order to test what it takes to transform a traditional practice into a PCMH practice. Practices were eligible for shared savings if they reported on quality measures and reduced the average costs of care for patients attributed to the same practice in 2010 and 2011.

In 2012, fifty of the fifty-two practices successfully reported quality measures and a total of 23 practices were eligible for shared savings based on reductions in total costs and their submission of quality measure data. These 23 practices will receive approximately $815,770 in shared savings from the five participating carriers. In 2013, goals include growing the number of participating practices and bringing in self-insured employers to the program.

INTRODUCTION AND BACKGROUND

Council's Establishment and Purpose

In October 2007, Governor Martin O'Malley established by executive order the Maryland Health Quality and Cost Council (Council).

The Council is tasked with providing the leadership, innovation, and coordination of multiple stakeholders within our health system—payers, institutional providers, physicians, government, patients, and citizens—in an effort to improve the health of Maryland's citizens, maximize the quality of health care services, and contain health care costs.

The Governor's executive order suggests the promotion of wellness, the adoption of advancements in disease prevention and chronic care management, the increased diffusion of health information technology (HIT), and the development of a chronic care plan as important strategies for the Council to consider.

To further define and guide its work, the Council has articulated the vision and mission statements listed below.

> **Vision Statement:** The State of Maryland is a demonstrated national leader in the implementation of innovative, effective cost containment strategies and the attainment of health and high quality health care. The State's efforts are guided by a commitment to ensuring that care is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.
>
> **Mission Statement:** To maximize the health of the citizens of Maryland through strategic planning, coordination of public and private resources, and evaluation that leads to: effective, appropriate, and efficient policies; health promotion and disease prevention initiatives; high quality care delivery; and reductions in disparities in healthcare outcomes.

Council Membership

In addition to the Lieutenant Governor and the Secretary of the Department of Health and Mental Hygiene, who serve as the Council's Chair and Vice Chair, respectively, the Council consists of twelve other members, each appointed by the Governor for a three-year term. In accordance with the executive order, the Council has at least one representative each drawn from the ranks of the health insurance industry, employers, health care providers, health care consumers, and health care quality experts.

Three of the Council's members represent provider organizations. James Chesley, Jr., M.D. is a practicing gastroenterologist with offices in Prince George's County. Barbara Epke is

Vice President at LifeBridge Health System, which consists largely of Sinai Hospital, Northwest Hospital, Levindale Hebrew Geriatric Center and Hospital, and the Jewish Convalescent & Nursing Home, in Baltimore City and Baltimore County. Christine R. Wray, F.A.C.H.E. is President of MedStar St. Mary's Hospital in Leonardtown, Maryland and Senior Vice President, MedStar Health, Inc.

Two of the Council's members are drawn from the ranks of the state's teaching institutions and represent, respectively, medicine and nursing. E. Albert Reece, M.D., Ph.D., M.B.A. is the Dean of the University of Maryland School of Medicine, located in Baltimore City, and also Vice President of Medical Affairs for the University of Maryland System. Kathleen White, Ph.D., R.N. is an Associate Professor and Director of the Master's Program at the Johns Hopkins School of Nursing, also in Baltimore City.

Two Council members represent large employer groups. Jill Berger is Vice President for Health and Welfare Plan Management and Design for Marriott International, headquartered in Montgomery County, and Roger Merrill, M.D. is Chief Medical Officer for Perdue Farms Incorporated, based in Wicomico County on the Eastern Shore.

Jon Shematek, M.D. represents the voices of health insurers on the Council. Dr. Shematek serves as Senior Vice President and Chief Medical Officer for CareFirst BlueCross BlueShield, the largest private insurer in Maryland.

New to the Council in 2012 is Nicolette Vernick, M.P.A., who serves as President and CEO of the Horizon Foundation, an independent philanthropy focused on improving health and wellness in Howard County. Ms. Vernick represents the voice of consumers on the Council.

Finally, four of the Council's members are nationally recognized experts on three different facets of health care quality, namely managed care, inpatient care, and health disparities. Peggy O'Kane, who is a Maryland resident, is the President of the National Committee for Quality Assurance (NCQA), a leading developer of quality and performance measures for managed care organizations located in Washington, DC. Richard (Chip) Davis, Ph.D., is the Vice President for Innovation and Patient Safety at Johns Hopkins Medicine in Baltimore City, Lisa A. Cooper, M.D., M.P.H, F.A.C.P., is a Professor of Medicine and Director of the Center to Eliminate Cardiovascular Disparities at the Johns Hopkins School of Medicine, and Marcos Pesquera is Executive Director of the Center on Health Disparities for Adventist HealthCare, Inc.

COUNCIL INITIATIVES AND ACTIVITIES

In accordance with Executive Order 01.01.2007.24, the Council is required to submit annually an update of activities for the previous year as well as recommendations for improving health care quality and reducing health care costs in the State. To guide this task, the Council has established the following priorities:

- Develop actionable wellness and prevention strategies to be integrated into a chronic care and disease management plan;
- Coordinate multi-phased quality and patient safety initiatives for acute hospitals settings; and,
- Facilitate statewide implementation of a Patient-centered Medical Home (PCMH) demonstration project.
- Develop actionable strategies to improve access and decrease health disparities for Maryland's minority populations; and
- Explore the current state of telemedicine in Maryland, and study the feasibility of expanding telemedicine services across the State.
- New in 2012, the Council has prioritized evaluating high-deductible health plans and exploring alternative solutions to reducing health plan costs while also prioritizing high-quality care.

Health Disparities Workgroup

The Health Disparities Workgroup is charged with exploring and developing health care strategies and initiatives, including financial, performance-based incentives, to reduce and eliminate health disparities, and make recommendations regarding the development and implementation of those strategies. The initiatives seek to:

- Improve quality and reduce costs;
- Build on existing efforts to address known disparities; and
- Identify best practice disparity programs in Maryland and across the country to determine if and how they should be implemented in Maryland.

Health Enterprise Zones

In late 2011, the Health Disparities workgroup, under the leadership of Dr. Albert E. Reece, Dean of the University of Maryland School of Medicine, released a final report laying out its strategy for reducing health disparities and meeting the workgroup's charge. A major part of the final report focused on the development of Health Enterprise Zones, which were defined as:

- A geographic area in Maryland that is eligible for specific policy incentives and funding opportunities for both new and existing providers. The HEZ will be a designated local community where special incentives and funding streams are available to address poor health outcomes by using healthcare-level, community-level, and individual-level interventions

- An HEZ can be defined in contiguous in geographic terms, has health outcomes and/or documented health disparities, and exhibits several characteristics that illustrate its need and potential for improvement;
- A major characteristic is that health metrics for the entire population or for racial/ethnic minorities' health outcomes, and/or documented health disparities in the area exceed State wide levels. This includes increased minority hospital admissions and Emergency Department visits as compared to the non-Hispanic white population, especially for asthma, diabetes, hypertension and other Ambulatory Care Sensitive Conditions (also called Prevention Quality Indicators).
- A Health Enterprise Zone has lower median family income than the State overall and higher unemployment, Medicaid enrollment or eligibility, and Free and Reduced Meals (FARMS) rates than the State overall.
- A Health Enterprise Zone has a collective community identity through active collaboration among community groups that include local government, community organizations, providers, hospitals, and insurers. A geographic area is recognized as a Health Enterprise Zone when it has clearly demonstrated these characteristics and been certified as an HEZ by the State.

Legislation

Lt. Governor Brown championed HEZs and led efforts to pass legislation authorizing their creation. In April, during the Maryland legislation session, Dr. Carlessia Hussein, DHMH Secretary Sharfstein as well as Lt. Governor testified at the Maryland General Assembly and SB 234 bill was passed on April 10, 2012 by the Governor. The FY 2013 budget allocated $4 million to the Community Health Resources Commission to fund the HEZs.

The bill established a process whereby the Secretary of DHMH, in collaboration with the Community Health Resources Commission (CHRC), would designate HEZs. To become an HEZ, a non-profit community-based organization or local health department had to apply to DHMH and CHRC with a comprehensive plan to address disparities in a defined geographic area. The bill contained several possible incentives that can be utilized to address disparities within the HEZ including:

- Loan assistance repayment;
- Income tax credits;
- Priority to enter the Maryland Patient Centered Medical Home Program;
- Grant funding from CHRC; and
- Priority for receiving funds for establishing an electronic health records program.

The bill also required MHCC to establish and incorporate a standard set of measures regarding racial and ethnic variations in quality and outcomes and track health insurance carriers' and hospitals' efforts to combat disparities. In addition, state institutions of higher education that train health care professionals will be required to report to the Governor and General Assembly on their actions aimed at reducing health care disparities.

Outreach and Application Process

A series of public meetings were held across Maryland over the summer of 2012 to describe the opportunity, encourage applications, and answer questions. Around the same time, DHMH and CHRC requested public comment on three documents:

- Threshold eligibility criteria for HEZ applicants;
- Additional benefits that could be provided by the state to assist HEZ awardees; and
- Principles that will be used to review HEZ applications.

The public comment period closed on July 20. More than 150 comments were received, which led to a range of changes in the proposals.

Following legislative review, DHMH and the CHRC released the HEZ Call for Proposals on October 5, 2012. The Call for Proposals is based on the threshold eligibility criteria and review principles distributed for public comment earlier and summarized in the report submitted to the legislature. Proposals were due to CHRC on Thursday, November 15, 2012, and the CHRC received 19 submissions (a list of applicants in in Appendix B). The CHRC evaluated the HEZ proposals and issued recommendations. A select number of the highest-ranked proposals will be invited to present to the Board of the CHRC on Tuesday, December 11 at 2:00 pm in Annapolis (Room 230, Maryland House of Delegates). HEZ designations were to be made by the Secretary in December 2012, and it is anticipated that approximately two to four HEZs will be selected. The selected HEZs were not available when this report was finalized in early December 2012.

Wellness and Prevention Workgroup

The Wellness and Prevention workgroup developed actionable wellness and prevention strategies that fulfill the Maryland Health Quality and Cost Council's (HQCC) efforts to advance wellness, prevention, and chronic care management toward the overarching goal of a healthier State. The aim is to make healthier choices easier, such as eating healthier, being physically active, and adhering to recommended preventive screenings and treatment.

Strategy 1: Implement Healthiest Maryland throughout the State.

Healthiest Maryland is a grasstops movement engaging leadership in communities, schools, businesses, and healthcare to make organizational commitments to promote wellness within their sphere of influence. The goal of this movement is to create healthy and supportive environments where Marylanders live, learn, work, and play through four complementary components. Healthiest Maryland Businesses was prioritized by the HQCC with the purpose of creating a culture of wellness at all Maryland workplaces.

Healthiest Maryland Businesses

The Healthiest Maryland Businesses (HMB) initiative is the cornerstone of the Healthiest Maryland Initiative. Participating businesses are referred to accredited workplace wellness resources and receive education and technical assistance. Participants are recognized for

their commitment and businesses that demonstrate best practices in implementing comprehensive wellness practices that promote total worker health are given special recognition.

Recruitment. To date 175 companies have enrolled in and made an organizational commitment (a list of participants is located in Appendix C). Participating companies are located in 22 Maryland jurisdictions and reach over 200,000 full-time Maryland employees.

Technical Assistance. The HMB preliminary evaluation reported that Maryland companies need technical assistance and diverse trainings to make sustainable changes at the workplace. Specific HMB technical assistance and training activities include:

- Providing direct consultation by a Certified Worksite Wellness Specialist;
- Planning, promoting, and holding regional HMB events and collaborating with partners to provide educational opportunities—reaching 575+ participants;
- Referring participants to local supporting organizations (wellness experts with different subject matter expertise);
- Updating HMB website to include a step-by-step guide to implementing a results-oriented program and matrix of recommended strategies,
- Capturing successes and developing "library" of program stories; and
- Promoting relevant wellness opportunities to participants through email.

Another success of HMB's technical assistance efforts is increasing the number of Supporting Organizations (workplace wellness partners with subject matter expertise) from 16 to 27. This resulted in the development of new partnerships with organizations that have adequate knowledge and resources in critical areas. Recognition efforts have been expanded to highlight worksite wellness success stories as the Department published its first Healthiest Maryland Businesses Success Stories. Please see Appendix D for current HMB Success Stories.

Next Steps. The Wellness and Prevention Workgroup's on-going efforts for 2013 with Healthiest Maryland Businesses will include partnering with local groups to increase recruitment, participating in regional forums, and creating Council specific HMB success stories. New activities will include developing a menu of recommended interventions, providing additional technical assistance on program implementation, piloting the CDC's Worksite Health Scorecard as a comprehensive program assessment tool, developing a framework to recognize participants, and promoting the evaluation publication.

Strategy 2: The State of Maryland will establish an Interagency Health and Wellness Task Force to design and implement statewide wellness practices.

In 2011, the Wellness and Prevention Workgroup agreed to champion the promotion of healthy food procurement practices for the State of Maryland as an employer and large purchaser. The Workgroup further recommended that an Interagency Health and Wellness Task Force be created to design and implement this healthy practice along with other comprehensive wellness programs on a broader scale.

Wellness Stat

The Governor's StateStat division developed a subject matter stat, known as Wellness Stat, to act as an interagency health and wellness group to guide, design and implement state employee wellness programs. In 2012, participating agencies developed the Maryland State Employee Wellness Initiative Schedule, through which Wellness Stat will disseminate relevant materials to participating state agencies on various subjects, including Healthy Maryland Week, Maryland Quitline, ChopChop Maryland recipes, healthy eating, physical activity, covered preventive service benefits, etc.

Next Steps. Wellness Stat also discussed the feasibility of implementing healthy food procurement practices in state facilities and agencies, assessed existing procurement practices, and identified facilitators/barriers to success. The group recommended that a state government food procurement workgroup be established to develop nutrition guidelines and develop strategies to overcome barriers toward implementation. Wellness Stat will also consider establishing additional task-specific workgroups, in alignment with the three overarching goals. To enhance agency accountability, State Stat is considering identifying measures that could be inserted into all agency State Stat templates.

Strategy 3: Align and guide statewide Million Hearts efforts and share successes.

The Maryland HQCC supports the Million Hearts™ Initiative, which aims to prevent 1 million heart attacks and strokes in the United States over the next 5 years by emphasizing the ABCS—Aspirin for those at risk, Blood pressure control, Cholesterol management, and Smoking cessation. This year the workgroup released a Million Hearts Action Plan, which includes the following focus areas: Improving clinical care; strengthening tobacco control; promoting a healthy diet and daily physical activity; encouraging workplace wellness; and incentivizing local public health action. The Action Plan is in alignment with the Maryland Department of Health and Mental Hygiene's commitment to the Million Hearts™ initiative and complements Maryland's Million Hearts Implementation Guide.

2012 Wellness and Prevention Workgroup Accomplishments

- Recruited more than 175 companies, reaching over 263,000 Maryland employees;
- Enhanced HMB referrals (e.g. provided technical assistance events reaching over 575 employers, health departments, brokers, vendors) and recognition components (e.g. published success stories);
- Launched phase one of the State Employee Wellness Initiative
- Prohibited the sale of tobacco-products at state agencies and facilities;
- Ensured 1,250 Harford County employees and all residents and visitors to county recreation facilities are protected from secondhand smoke exposure through Harford County's implementation of a tobacco-free requirement
- Trained 18 child care providers in Worcester County on foster child care environments that support healthy choices that could help prevent childhood obesity;
- Published Council Million Hearts Action Plan;
- Participated in Maryland Million Hearts Webinar and plan for statewide stakeholder event;

2013 Wellness and Prevention Workgroup Milestones

- Recruit a total of 250 companies to participate in HMB (December 2013);
- Identify and recognize at least 15 companies for their successful wellness programs (December 2013);
- Promote final worksite wellness evaluation publication to relevant stakeholders (on-going);
- Provide guidance to Wellness Stat workgroups (on-going);
- Implement components of the CTG communication plan by disseminating CTG success stories (on-going); and
- Participate in the planning and implementation of a Maryland Million Hearts event (March 2013)

Cultural and Linguistic Competency Workgroup

In April 2012, Governor O'Malley signed into law, SB 234, the Maryland Health Improvement and Disparities Reduction Act of 2012. 20904-Section 4, calls for the Maryland Health Quality and Cost Council to (1) convene a workgroup to examine standards for cultural and linguistic competency, (2) assess the feasibility of and develop recommendations for multicultural health care equity in the Patient Centered Medical Home program, and (3) recommend criteria for health care providers to receive continuing education in multicultural health.

Progress to Date

Secretary Sharfstein appointed Dr. Lisa Cooper and Mr. Marcus Pesquera as Co-Chairs of the newly established Cultural Competency Workgroup in September 2012. After receiving seventy nominations, forty-nine persons were appointed by the Secretary to serve on the Workgroup, making for a total of 51 persons counting the Co-Chairs. A list of these individuals can be found in Appendix A. A staff support group (external to DHMH) made up of representatives from disparities centers and interested professionals and advocates was also established. This group of 12 individuals will assist the State staff to provide support to the Workgroup. The first meeting was held in November 2012. The Co-Chairs covered the charge to the workgroup, an overview of SB 234 and the MHQCC, and a draft work plan. Members were asked to submit input on the work plan and to identify areas of interest.

Evidence-Based Medicine Workgroup

The Evidence-Based Medicine Workgroup is charged with prioritizing the widespread implementation of a discrete set of practices that have been shown to improve health care quality, decrease cost and could be instituted on a large scale relatively quickly. The Council initially termed such practices "low-hanging fruit" because the practices to be considered by the group were to be those that are evidence based, with little or no debate about their effectiveness, and that could be implemented in relatively short time periods. While initial efforts focused on hospitals, new initiatives are focused on health plans.

Overview
In 2012, Peggy O'Kane, President of NCQA, was named the new chair of the Evidence-Based Medicine workgroup. As leader of one of the nation's leading authorities on quality improvement, she brings tremendous insight and know-how to the workgroup. The other Council members who participate in this workgroup are Barbara Epke, James Chesley, Chip Davis, Kathy White, and Roger Merrill. Regular participants also include Robert Imhoff of the Maryland Patient Safety Center, Bev Miller and Nicole Stallings from the Maryland Hospital Association, and Dianne Feeney from HSCRC.

The workgroup generally holds two conference calls between quarterly Council meetings. All calls are publicized on the HQCC website so the public may join in. The calls include an update on ongoing collaboratives/projects and any interventions necessary to keep them on track, then topics for future projects are discussed. Two large collaborative projects, Hand Hygiene and track healthcare-acquired infections, continued in 2012.

Strategy 1: Value-Based Insurance Design
In 2012, the Council began evaluating high-deductible health plans, which require high levels of cost sharing by beneficiaries and have been shown to result in poor quality of care and poor health outcomes. It became a priority of the Council to explore and promote alternative health plan designs that are low cost but also promote high-quality care.

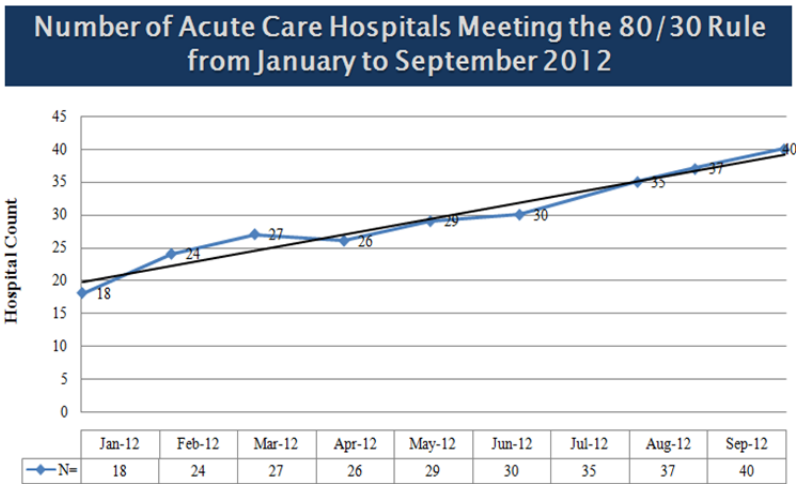
Under the new leadership of Peggy O'Kane, the Evidence-Based Medicine workgroup began pursuing value-based insurance design (VBID) as a new strategy for health plan design. VBID incentivizes health plan enrollees to utilize high-value health services by adjusting cost-sharing (e.g., co-payments). For instance, services such as well-child visits, primary care visits for persons with chronic diseases, smoking cessation, weight management programs, and colonoscopies may be available at no out-of-pocket cost. At the same time, services shown to be of low value when studied may require a higher co-payment.

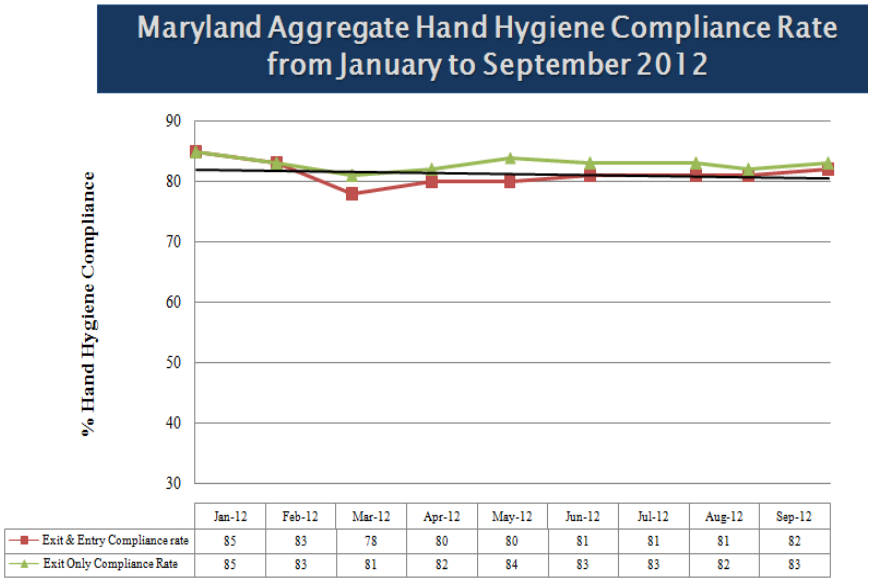
Experts and other with experience implementing VBID presented to the Council at its December 2012 meeting. These lessons learned will be used by the workgroup to develop a work plan for integrating VBID into health plans in Maryland. This effort will be the primary focus of the workgroup in 2013.

Strategy 2: The Maryland Hospital Hand Hygiene Collaborative
The Maryland Hospital Hand Hygiene Collaborative (Collaborative) began in 2010 with the goal to reduce preventable infections through better hand hygiene. The Collaborative is a voluntary, statewide effort led by the Maryland Patient Safety Center (Center) with support from the Maryland Hospital Association and Delmarva Foundation and in partnership with the Maryland Health Quality and Cost Council and the Department of Health and Mental Hygiene. The Collaborative involves the use of trained, unknown observers to collect hand hygiene compliance observations for healthcare providers upon entry and/or exit from the patient environment for adult and pediatric inpatient units and critical care units (required units). To be fully participating in the Collaborative, hospitals must have 80% of their required units reporting with 30 or more observations; this is known as the 80/30 rule. As the graphs on the next page show, progress continues to be made in increasing compliance.

The Maryland Patient Safety Center developed a hospital engagement action plan in January 2012 that focused on increasing engagement among participating hospitals. The action plan addressed a number of activities to recruit additional hospitals into the Collaborative and to raise the level of participation and compliance with hospitals already participating. Specifically, the Center, in partnership with the Delmarva Foundation and the Maryland Hospital Association:

- established a campaign to recruit all Maryland hospitals into the Collaborative,
- conducted a monthly analysis of hospital participation to determine the barriers to meeting minimum participation requirements,
- created hospital-specific performance reports (participation summaries and report cards) to be distributed to hospital CEOs and infection preventionists each month,
- created an infection dashboard report that is distributed to hospital CEOs on a quarterly basis to illustrate associations between hand hygiene compliance and MHA's hospital-specific infection data,
- created a monthly hand hygiene update report to DHMH.





Strategy 3: Reduce Healthcare-Acquired Infections

Related to the hand hygiene project is an effort to monitor and reduce healthcare-acquired infections (HAIs). HAIs, which are infections that patients acquire while receiving care for other conditions, account for an estimated 1.7 million infections and nearly 100,000 deaths in the U.S. annually. Bloodstream infections (BSIs), catheter associated urinary tract infections (CAUTIs), surgical sites infections (SSIs), and ventilator-associated pneumonia (VAP) account for more than 80 percent of all HAIs. There are 250,000 cases of central line-associated blood stream infections (CLABSIs) annually. Maryland law mandates surveillance and public reporting of CLABSIs, SSIs, and health care worker flu immunization. In FY11, there was a 37 percent reduction in CLABSI at all intensive care units (ICUs). Full CLABSI results comparing 2011 to 2010 in the table below.

Performance Measure	FY2010	FY2011	Difference
All ICU CLABSIs	**472**	**296**	**Improvement (37.29% reduction)**
Adult/Pediatric Intensive Care Units			
CLABSIs	424	262	Improvement **(38.21% reduction)**
Hospitals with 0 Infections	7	12	Improvement
Hospitals Better than National Experience	0	4	Improvement
Hospitals Same as National Experience	37	39	Improvement
Hospitals Worse than National Experience	8	2	Improvement
Maryland Standardized Infection Ratio (SIR)*	1.35	0.85	Improvement
Maryland Performance (using SIR)	**Worse**	**Better**	**Improvement**
Maryland Adult/Ped ICU Central Line Days	**163,757**	**157,706**	
Neonatal Intensive Care Units (NICUs)			
Hospitals with NICUs	15	16	
CLABSIs (total)**	48	34	Improvement **(29.17% reduction)**
Hospitals with 0 Infections	5	3	No Improvement
Hospitals Better than National Experience	1	2	Improvement
Hospitals Same as National Experience	14	14	No Change
Hospitals Worse than National Experience	0	0	No Change
Maryland NICU Central Line Days	**18,453**	**18,659**	

Next steps for this effort include assessing Maryland's infection prevention efforts. This will include antimicrobial stewardship, environmental cleaning, screening, isolation, infection control, and health care worker immunization. This assessment will drive interventions for improvement. They also plan to enhance current surveillance by targeting specific organisms and piloting new techniques and data collection mechanisms.

Strategy 4: Implement a statewide telemedicine network

The Telemedicine Task Force presented *Telemedicine Recommendations – A Report Prepared for the Maryland Health Quality and Cost Council* at the Council's final 2011 meeting. This document was included as an appendix in the Council's 2011 Annual Report. In 2012, the following activities to implement the recommendations occurred:

State-regulated payers should reimburse for telemedicine services

This recommendation resulted in Senate Bill 781, *Health Insurance - Coverage for Services Delivered through Telemedicine*, which was signed into law by Governor Martin O'Malley in May 2012. The law became effective on October 1, 2012 and requires that health insurers and managed care organizations (MCOs) provide coverage for health

care services delivered appropriately using telemedicine technology, and that coverage cannot be denied because services were provided through telemedicine rather than in-person. Insurers are not required to cover telemedicine services if the health service would not be a covered benefit even if provided in-person, or if the telemedicine provider is out-of-network.

Establish a centralized telemedicine network built on existing industry standards

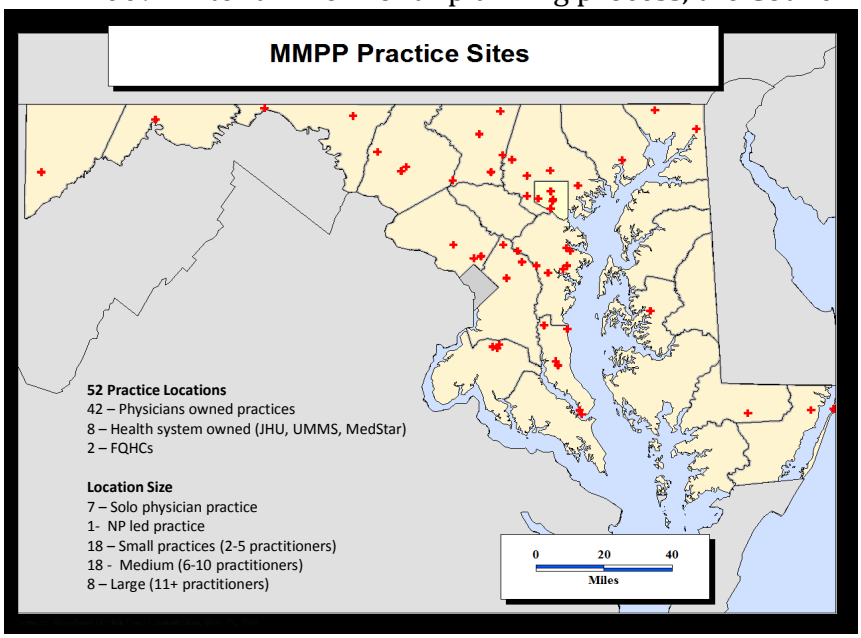
An interoperable telemedicine network that is built on existing standards and is integrated into the health information exchange (HIE) would enable broad provider participation, allow networks to connect to other networks, and facilitate access to clinical information from disparate organizations. In the summer of 2012, MHCC continued to work with the Telemedicine Technology Solutions and Standards Advisory Group and began developing a telemedicine technology implementation resource guide. In the fall of 2012, the advisory group is working to identify a range of best practices for telemedicine as it relates to infrastructure, clinical devices, hardware, and data exchange standards, which are critical to ensuring that telemedicine networks across the state can easily communicate.

Although telemedicine is well established, a number of technology and policy challenges need to be resolved before its full potential can be realized. Changes in licensure, credentialing, and privileging of providers are needed to facilitate the adoption of telemedicine.

Patient-Centered Medical Home Workgroup

Overview

The Patient Centered Medical Home Program was adopted as an initiative by the HQCC in 2009. After a nine-month planning process, the Council determined that legislation was needed to authorize an incentive-based reimbursement structure and to permit payers to collaborate on a multi-payer program. Legislation enacted by the Maryland General Assembly in 2010 and effective July 1, 2010, charged the Maryland Health Care Commission (MHCC, or Commission) to establish a program if it concluded that the program is likely to result in the delivery of more efficient and effective



health care services and is in the public interest (Maryland Annotated Code, Section 19-1A.) The statute requires that the program promote the development of patient centered medical homes by adopting standards, forms and processes with consultation of stakeholders. This pilot program is known as the "Maryland Multi-Payer Patient Centered Medical Home," or "MMPP."

As a result of a state-wide recruitment effort, 53 practices reflecting a broad range of practice sizes, structures and geographic locations were selected in order to test what it takes to transform a traditional practice into a PCMH practice. The map above depicts the participating MMPP practices. The Commission notes that since the program's inception, only one practice has chosen to leave the program.

FY 2012 Achievements

The eight main achievements for the MMPP for the fiscal year were:

- Evaluation contract awarded to IMPAQ International– January 2012;
- 52 practices achieved NCQA Level I or better, with two-thirds of the practices achieving Level II or III;
- 52 practices submitted quality measure data using EHR or registries;
- Comprehensive external evaluation program launched;
- Increased Medicaid funding for FY 2012-2013 secured (from $1.5 to $2.9 mm);
- Shared savings methodology confirmed using CY 2009-2010 claim data;
- Shared savings methodology implemented using CY 2010-2011 private carrier claim data; and
- Shared savings were awarded to 23 practices; and the five private payers were instructed to make payments (Announced in October 2012).

Table 1: Quality Reporting Results

Shared Saving Eligibility	# of Practices	Pediatric	Adult	Both
Maximum Measures		5	18	21
50%	20	2	8	10
40%	20	3	3	14
30%	9	1	1	7
0%	1	0	1	0
Did not report	2	1	1	

Summary of Shared Savings Data 2010/2012

Under the MMPP participation agreement practices were eligible for shared savings if they reported on quality measures and reduced the average costs of care for patients attributed to the same practice in 2010 and 2011. Fifty of the fifty-two practices successfully reported quality measures. Table 1 presents the results from the quality reporting for 2011.

A total of 23 practices were eligible for shared savings based on reductions in total costs and their submission of quality measure data. These 23 practices will receive approximately $815,770 in shared savings from the five

Table 2: Distribution of Practices Receiving Shared Savings in 2012

Earned Savings	# of Practices	Pediatric	Adult	Both
Yes	23	1	6	16
No	27	5	7	17

participating carriers. The distribution of practices receiving shared savings is shown in Table 2.

Factors Affecting Savings

The shared savings program is premised on the assumption that the PCMH model will reduce patient hospital days, ER visits, and readmissions. There was a fairly strong association between reduced spending and reduced hospital days, as one would expect. There was not a strong association between shared savings and reduced ER use or readmission during the first six months of the program. The lack of any association between shared savings and readmission days is likely due to the infrequent number of readmissions among the privately insured population. The weak relationship between savings and ER use will be carefully monitored in the second year of the program, when we expect more complete patient engagement and awareness about the features of a PCMH practice, including extended hours and care management. Commission staff cautions that most state pilot programs do not see shared savings after the first full year and the data presented here reflect a partial year of operation.

Goals for 2013

- Expand payer and self-funded employer participation;
- Ensure all participating practices achieve NCQA Level II or III;
- Determine path to sustainability for the Maryland Learning Collaborative;
- Implement quality measurement performance thresholds;
- Implement shared savings methodology for Medicaid; and
- Disseminate preliminary findings and baseline data for the external evaluation.

Maryland Learning Collaborative

The principal agent for practice transformation and quality improvement in the MMPP practices is the Maryland Learning Collaborative (MLC). The MLC is a partnership that combines resources from the education and research communities with the commitment and knowledge of clinicians committed to advancing primary care. The Commission funded the MLC at $790,000 over three years (2011-2013). Additional support for the MLC in the amount of $120,000 was secured from private sources. In 2012, the MLC deployed practice transformation coaches and conducted two large peer learning meetings and seven small regional peer learning activities throughout the last fiscal year. The MLC was essential in gaining the support of NCQA staff to promote full understanding of NCQA criteria and to expedite review processes.

MLC Accomplishments

- All practices submitted and achieved NCQA Level I or better in 2011; and
- In 2012, all practices submitted and achieved NCQA Level II or better except three sites, which had deadline extensions of one to three months
    - Deferments were primarily related to technical/EHR system issues

APPENDICES

Appendix A: Workgroup Meeting Dates and Participants

Health Disparities Workgroup

Council Members
E. Albert Reece, (Chair)
Marcos Pesquera
Lisa Cooper

Staff
Brian DeFilippis, University of Maryland School of Medicine
Carlessia Hussein, Department of Health and Mental Hygiene
David Mann, Department of Health and Mental Hygiene
Ben Stutz, Office of the Lieutenant Governor

Other Participants
Oxiris Barbot, Baltimore City Health Department
Claudia Baquet, University of Maryland School of Medicine
Michael Chiaramonte, Southern Maryland HealthCare System
Renee Fox, University of Maryland School of Medicine
Darrell Gaskin, Johns Hopkins Bloomberg School of Public Health
Jay Magaziner, University of Maryland School of Medicine
Ligia Peralta, University of Maryland School of Medicine
Steven Ragsdale, Johns Hopkins University
Stephen Thomas, University of Maryland College Park

HEZ Public Meeting Dates and Locations
July 11, Waldorf
July 19, Baltimore
July 26, Silver Spring
August 2, Oxon Hill
September 13, Salisbury
September 25, Cumberland

Wellness and Prevention Workgroup

Council Members
Christine Wray (Chair)
E. Albert Reece,
James S. Chesley

Jon Shematek
Peggy O'Kane
Roger Merrill

Staff
Frances Phillips, DHMH
Katie Jones, DHMH
Maria Prince, DHMH

Other Participants
Nicole Stallings, Maryland Hospital Association
John Martin, Cardiology Associates, LLC
Joan Gelrud, MedStar St. Mary's Hospital

Meeting Dates
February 15
April 16
August 23
October 25

Cultural and Linguistic Competency Workgroup

Council Members
Lisa A. Cooper, M.D., M.P.H., F.A.C.P., Professor of Medicine, Johns Hopkins University School of Medicine; Director, Johns Hopkins Center to Eliminate Cardiovascular Disparities

Marcos Pesquera, R.Ph., M.P.H., Executive Director, Center on Health Disparities, Adventist HealthCare, Inc.

Workgroup Members
Salliann Alborn, CEO, Maryland Community Health System, Community Health Integrated Partnership

Linda Aldoory, PhD, Endowed Chair and Director, Herschel S. Horowitz Center for Health Literacy, Associate Professor, Department of Behavioral & Community Health, University of Maryland College Park School of Public Health

Thomas E. Arthur, MEd, MHA, President, Thomas E. Arthur and Associates

Brandon Batiste, Director, Johns Hopkins Medicine

Cyntrice Bellamy-Mills, MEd, MS, Administrator, Behavioral Health Programs Department of Health and Mental Hygiene, Mental Hygiene Administration

Olivia Carter-Pokras, PhD, Associate Professor, Epidemiology, University of Maryland College Park School of Public Health

Roger S. Clark, MBA, Chief Operating Officer, Medical Home Development Group

Chiquita Collins, PhD, Assistant Dean for Diversity and Cultural Competence, Johns Hopkins University, School of Medicine

E. Keith, Colston, Director, Maryland Commission on Indian Affairs, Governor's Office of Community Initiatives

Barbara, Cook, MD, Medical Director, The Access Partnership, Johns Hopkins Medical Institute

Florence Veronica Deza, MD, Director of Geriatrics, MedStar Franklin Square Medical Center

Doris Dzameshie, PhD, President, African Immigrants and Senior Citizen Institute
Janice Berry Edwards, PhD, ACSW, LICSW, Assistant Professor, Howard University School of Social Work

Earl Ettienne, PhD, MBA, Assistant Professor, Howard University College of Pharmacy

Wendy Friar, RN, MS, Vice President of Community Health, Holy Cross Hospital

Columbus Giles, MD, Medical Director, Delmarva Foundation for Medical Care

Maria S. Gomez, RN, MPH, President and CEO, Mary's Center

Larry Gourdine, Executive Director, Monumental City Medical Society

Leslie Grant, DDS, Dental Compliance Officer, Maryland State Board of Dental Examiners

Dianne Houston-Crockett, MEd, MPH, CHES, Associate Vice President, Health Promotion, Amerigroup Maryland, Inc.

Jerry Howard, II, MBA, Project Manager, The Maryland Center, Bowie State University

Anna Marie Izquierdo-Porrera, MD, PhD, Executive Director and Co-Founder, Care For Your Health, Inc.

Cheryl Jones, MBA, MHA, PHR, Director of Outreach, Chesapeake Regional Information System for Our Patients (CRISP)

Senator Verna Jones-Rodwell, MPA, State Senator - 44th Legislative District, Maryland General Assembly

Sosena Kebede, MD, MPH, Assistant Professor of Medicine, Johns Hopkins University

Niharika Khanna, MBBS, MD, DGO Director, University of Maryland School of Medicine, Maryland Learning Collaborative

Sandra Kick, MSPH, Health Policy Analyst, Maryland Women's Coalition for Health Care Reform

Yemisi (Oluyemisi) Koya, MD, JD, Manager, Communication, Education and Policy, Maryland Board of Physicians

Betty Lam, MA, Chief, Montgomery County Health and Human Services, Office of Community Affairs

Thomas LaVeist, PhD, Director of the Hopkins Center for Health Disparities Solutions, William C. and Nancy F. Richardson Professor in Health Policy, Johns Hopkins Bloomberg School of Public Health

Austria Lavigne Hooks, MD, Medical Director, Aetna U.S. Healthcare Patient Management
Susan Leggett-Johnson, MD, MBA, Associate Medical Director and Diversity Officer, Kaiser Permanente

Chimene Liburd, MD, MBA, FACP, Representative, Maryland Chapter of the American College of Physicians

Yolanda Maria Welch Martinez, Chair, Governor's Commission on Hispanic Affairs; Founder and CEO, Respira Medical

Monica McCann, MA, MPH, Workforce Diversity Director, Maryland Office of Minority Health and Health Disparities,

Sonia Mora, MPH, Chair, Health Committee, Governor's Commission on Hispanic Affairs; Manager of the Latino Health Initiative, Director of the Suburban Maryland Welcome Back Center, Montgomery County Department of Health and Human Services

Yolanda Ogbolu, PhD, CRNP, Researcher, Professor, Deputy Director for the Office of Global Health University of Maryland School of Nursing

Philip Osteen, PhD, Assistant Professor, University of Maryland, Baltimore, School of Social Work

Ligia Peralta, MD, FAAP, FSAHM, Tenured Associate Professor of Pediatrics and Epidemiology, University of Maryland Baltimore School of Medicine

Carol Reynolds – Freeman, MD, Medical Director, Potomac Physicians, P.A.

Scharmaine Robinson, RN, BSN, Chief, Health Benefit Plan Quality and Performance, Maryland Health Care Commission

Lorraine W. Smith, MA, MPH, Executive Director, Department of Health and Mental Hygiene Board Examiners of Psychologists

William Talley, RhD, Assistant Dean, Department Chair, and Professor University of Maryland Eastern Shore School of Pharmacy and Health Professions

Kima Joy Taylor, MD, MPH, National Director, Open Society Foundations, Drug Addiction Treatment and Harm Reduction Program

Daniel Teraguchi, EdD, Assistant Dean for Student Affairs, Director, Office of Student Diversity, Johns Hopkins University, School of Medicine

Fredette West, Director, African American Health Alliance

Aerlande Wontamo, MPH, Refugee Reception and Placement - Resettlement Manager, Lutheran Social Services of the National Capital Area
Sherman Yen, PhD, Asian American Advocate, Asian American Anti-Smoking Foundation

Mohammed Younus, MD, Psychiatrist, Instructor of Psychiatry, Catholic Charities, Child and Family Division & Johns Hopkins Hospital

Staff
Carlessia Hussein, DrPH, RN, Director, Office of Minority Health and Health Disparities, DHMH

Meeting Date
November 29

Evidence-Based Medicine Workgroup

Council Members
Peggy O'Kane (Chair)
Richard (Chip) Davis
James Chesley
Barbara Epke
Kathy White
Roger Merrill

Staff
Mary Mussman, DHMH
Laura Herrera, DHMH

Lucy Wilson, DHMH

Other Participants
Bev Miller, Maryland Hospital Association
Dianne Feeney and Steve Ports, HSCRC
Nicole Stallings, Maryland Hospital Association
Maria Prince, DHMH
Howard Carolan, Center for Innovation in Quality Patient Care at Johns Hopkins
Page Gambill, American Red Cross
Donna Marquess, LifeBridge Health
Joan Boyd, Lisa Shifflett and Richard Hill, Center for Innovation in Quality Patient Care at Johns Hopkins
Janice Hunt, UMMC
Ed Hamburg, MDE

Meeting Dates
January 26
February 24
April 9
May 16
August 1

Appendix B: Health Enterprise Zone Applicants

Applicant	Jurisdiction(s)	Zip Code(s)
Allegany County Health Department	Allegany County	21502
Primary Care Coalition of Montgomery County	Montgomery County	20903, 20912
Care for your Health Baltimore City	Baltimore City	21218, 21214
Somerset County Health Department	Somerset County	21853, 21851, 21838, 21817
Bon Secours Hospital	Baltimore City	21216, 21217, 21223, 21229
Dorchester County Health Department	Dorchester and Caroline Counties	21613, 21631, 21664, 21659, 21835, 21643, 21632
Cecil County Health Department	Cecil County	21921, 21901, 21911, 21904, 21903
Prince George's County Health Department	Prince George's County	21921, 21901, 21911, 21904, 21903
Charles County Department of Health	Charles County	20640, 20616, 20658, 20662
Baltimore County Department of Health	Baltimore County	21222, 21224, 21237, 21221, 21220
St. Mary's Hospital of St. Mary's County	St. Mary's County	20653, 20634, 20667
MedChi - Chestertown	Kent County	21620
Lower Shore Clinic	Wicomico County	1801, 21804, 21875
Sisters Together And Reaching - East Baltimore HEZ Collaborative	Baltimore City	21202, 21205, 21213
Calvert Memorial Hospital	Calvert County	20678
Laurel Regional Hospital/Dimensions Healthcare System	Prince George's County	20707, 20708, 20705
Asian American Center of Frederick/ L.I.F.E. & Discovery, Inc	Frederick County	21702
GOSPEL/Allen Chapel AME	Montgomery County	20904, 20866
Anne Arundel Medical Center	Anne Arundel County	21401

Appendix C: Healthiest Maryland Businesses Participants[1]

	Company	Location	Industry
1	Every Body Yoga and Wellness	Queen Anne's County	Other Services (except Public Administration)
2	Talbot County Health Department	Talbot County	Health Care and Social Assistance
3	Kent Center	Kent County	Health Care and Social Assistance
3	Camp Tockwogh	Kent County	Other Services (except Public Administration)
4	Town of Bladensburg	Prince George's County	Public Administration
5	Brick Bodies / Lynne Brick's	Baltimore County	Arts, Entertainment, and Recreation
6	GE Aviation; Middle River Aircraft Systems	Baltimore County	Manufacturing
7	Carroll Lutheran Village	Carroll County	Health Care and Social Assistance
8	My Transportation	Prince George's County	Transportation and Warehousing
9	Housing Opportunities Commission of Montgomery County	Montgomery County	Real Estate and Rental and Leasing
10	Choptank Transport	Caroline	Transportation and Warehousing
11	Town of Chestertown	Kent County	Public Administration
12	Harford-Belair Cardiometabolic Health Congress (CMHC)	Baltimore City	Health Care and Social Assistance
13	Hub Labels Inc.	Washington County	Manufacturing
14	Praxis Engineering	Anne Arundel County	Professional, Scientific, and Technical Services
15	Montgomery County Public Schools	Montgomery County	Educational Services
16	Anne Arundel County Government	Anne Arundel County	Public Administration
17	Cianbro	Anne Arundel County	Construction

[1] A Healthiest Maryland Businesses participant is a Maryland employer that has signed on to the initiative. Official enrollment entails completing a commitment letter and/or a brief organizational assessment.

18	City of Bowie	Prince George's County	Public Administration
19	Anne Arundel County Public Schools	Anne Arundel County	Educational Services
20	Kent County Department of Social Services	Kent County	Health Care and Social Assistance
21	Heron Point of Chestertown	Kent County	Health Care and Social Assistance
22	Kent Youth Inc.	Kent County	Other Services (except Public Administration)
23	Maryland Citizens Health Initiative Education Fund Inc.	Baltimore City	Other Services (except Public Administration)
24	Atlantic/Smith, Cropper & Deeley, LLC	Wicomico County	Finance and Insurance
25	iBiquity	Howard County	Other Services (except Public Administration)
26	Meritus Health Inc.	Washington County	Health Care and Social Assistance
27	Salisbury University	Wicomico County	Educational Services
28	Frederick Memorial Hospital	Frederick County	Health Care and Social Assistance
29	Corporate Network Services	Montgomery County	Professional, Scientific, and Technical Services
30	City of Taneytown	Carroll County	Public Administration
31	Playworks	Baltimore City	Educational Services
32	Northrop Grumman Corporation	Anne Arundel County	Professional, Scientific, and Technical Services
33	Deers Head	Wicomico County	Health Care and Social Assistance
34	City of Gaithersburg	Montgomery County	Public Administration
35	Arc of Washington County Inc.	Washington County	Health Care and Social Assistance
36	Price Modern LLC	Baltimore City	Retail Trade
37	Wicomico Co. Board of Education	Wicomico County	Educational Services
38	Pfizer Inc.	Baltimore City	Health Care and Social Assistance
39	Municipal Employees Credit Union of Baltimore (MECU)	Baltimore City	Finance and Insurance

40	Liesure Fitness	Montgomery County	Retail Trade
41	Dixon, Valve, and Coupling	Kent County	Manufacturing
42	Chesapeake Hearing Centers Inc.	Anne Arundel County	Health Care and Social Assistance
43	City of Greenbelt	Prince George's County	Arts, Entertainment, and Recreation
44	WellAdvantage	Carroll County	Health Care and Social Assistance
45	The Henry M. Jackson Foundation for the Advancement of Military Medicine	Montgomery County	Other Services (except Public Administration)
46	Work Smart Ergonomics	Baltimore City	Professional, Scientific, and Technical Services
47	Cecil County Health Department	Cecil County	Health Care and Social Assistance
48	Nexercise	Montgomery County	Professional, Scientific, and Technical Services
49	University Physcians, Inc	Baltimore City	Health Care and Social Assistance
50	City of College Park	Prince George's County	Public Administration
51	Pfizer	Prince George's County	Finance and Insurance
52	Joyous Living	Calvert County	Health Care and Social Assistance
53	JBS International	Montgomery County	Health Care and Social Assistance
54	Sport and Spine Rehab	Prince George's County	Health Care and Social Assistance
55	Reliable Contracting Co, Inc.	Anne Arundel County	Construction
56	Gillespie & Son Inc	Kent County	Manufacturing
57	Washington College	Kent County	Educational Services
58	David A. Bramble, Inc.	Kent County	Construction
59	Peninsula Cardiology Associates, P.A	Wicomico County	Health Care and Social Assistance
60	Euler Hermes	Baltimore County	Finance and Insurance
61	Jolles Insurance	Howard County	Finance and Insurance
62	Commercial Insurance Managers INC	Howard County	Health Care and Social Assistance

63	Injured Workers Insurance Fund	Baltimore County	Finance and Insurance
64	New Windsor State Bank	Carroll County	Finance and Insurance
65	Human Services Programs of Carroll County, Inc.	Carroll County	Health Care and Social Assistance
66	Innovative Benefit Solutions LLC	Worcester County	Finance and Insurance
67	MidAtlantic Business Group on Health	Prince George's County	Management of Companies and Enterprises
68	Shore Bancshares, Inc.	Talbot County	Finance and Insurance
69	Healthy Howard, Inc	Howard County	Health Care and Social Assistance
70	College of Notre Dame	Baltimore City	Educational Services
71	Perdue Farms	Anne Arundel and Wicomico County	Poultry Processing
72	Western Maryland Area Health Education Center (AHEC)	Allegany County	Health Care and Social Assistance
73	Jerry's Chevrolet Company	Baltimore County	Construction
74	Y of Central Maryland	Baltimore City	Health Care and Social Assistance
75	Adventist Healthcare	Montgomery County	Health Care and Social Assistance
76	Deutsch & Associates, LLC	Montgomery County	Finance and Insurance
77	Wisp Resort	Garrett County	Arts, Entertainment, and Recreation
78	The PharmaCareNetwork	Allegany County	Health Care and Social Assistance
79	AES Warrior Run	Allegany County	Utilities
80	Life Fitness Management	Allegany County	Other Services (except Public Administration)
81	The Horizon Foundation	Howard County	Other Services (except Public Administration)
82	George, Miles & Buhr	Wicomico County	Professional, Scientific, and Technical Services

83	Howard County Health Department	Howard County	Public Administration
84	Montgomery College	Montgomery County	Educational Services
85	Peninsula Regional Medical Center	Wicomico County	Health Care and Social Assistance
86	Marriott International	Montgomery County	Accomodation and Food Services
87	WMDT	Wicomico County	Information
88	Garrett County Memorial Hospital	Garrett County	Health Care and Social Assistance
89	QIAGEN	Montgomery County	Manufacturing
90	Wicomico Co. Health Dept.	Wicomico County	Health Care and Social Assistance
91	Medifast, Inc	Baltimore County	Other Services (except Public Administration)
92	SMECO	Charles County	Utilities
93	Atlantic General Hospital	Worcester County	Health Care and Social Assistance
94	The Bank of Delmarva	Wicomico County	Finance and Insurance
95	K&L Microwave, Inc.	Wicomico County	Manufacturing
96	Clear Channel Outdoor	Wicomico County	Other Services (except Public Administration)
97	Total Biz Fulfillment, Inc.	Garrett County	Transportation and Warehousing
98	Calvin B. Taylor Banking Company	Worcester County	Finance and Insurance
99	Mid-Delmarva Family YMCA	Wicomico County	Arts, Entertainment, and Recreation
100	Spirit Creative Services, Inc.	Anne Arundel County	Arts, Entertainment, and Recreation
101	Verizon	State-wide	Other Services (except Public Administration)
102	Union Hospital of Cecil County	Cecil County	Health Care and Social Assistance
103	Harford Community College	Harford County	Educational Services
104	Friends Aware	Allegany County	Other Services (except Public Administration)

105	Alliant Tech Systems	Out-of-State	Manufacturing
106	State of Maryland	State-wide	Public Administration
107	McCormick & Company, Inc.	Baltimore County	Manufacturing
108	National Aquarium	Baltimore City	Arts, Entertainment, and Recreation
109	City of Cumberland	Allegany County	Public Administration
110	Business Health Services	Baltimore City	Professional, Scientific, and Technical Services
111	A&G Pharmaceutical Inc.	Howard County	Health Care and Social Assistance
112	David Edward	Baltimore County	Manufacturing
113	Mel's Business Systems, Inc	Allegany County	Retail Trade
114	Gliknik Inc.	Baltimore City	Professional, Scientific, and Technical Services
115	Forest City - NEBP	Baltimore City	Construction
116	Thrasher Engineering	Garrett County	Professional, Scientific, and Technical Services
117	ACT Personnel Service, Inc.	Allegany County	Professional, Scientific, and Technical Services
118	Rummel, Klepper & Kahl LLP (RK&K)	Baltimore City	Professional, Scientific, and Technical Services
119	Miltec Corporation	Queen Anne's County	Manufacturing
120	Goodwill Industries of the Chesapeake, Inc.	Baltimore City	Other Services (except Public Administration)
121	Ulman Cancer Fund for Young Adults	Howard County	Other Services (except Public Administration)
122	City of Rockville	Montgomery County	Public Administration
123	Ayers/Saint/Gross	Baltimore City	Professional, Scientific, and Technical Services
124	MedStar Health, Inc.	Howard County	Health Care and Social Assistance

125	City of Frederick	Frederick County	Public Administration
126	Kent County Public Schools	Kent County	Educational Services
127	Anne Arundel Medical Center	Anne Arundel County	Health Care and Social Assistance
128	Kent County Health Department	Kent County	Health Care and Social Assistance
129	BioMarker Strategies	Baltimore City	Professional, Scientific, and Technical Services
130	Chester River Health System	Kent County	Health Care and Social Assistance
131	Saint Agnes Hospital	Baltimore City	Health Care and Social Assistance
132	Easton Utilities	Talbot County	Utilities
133	Johns Hopkins Health System / Johns Hopkins Hospital	Baltimore City	Health Care and Social Assistance
134	Richard J Princinsky and Associates	Baltimore County	Finance and Insurance
135	Upper Chesapeake Health	Harford County	Health Care and Social Assistance
136	Shore Health System	Dorchestor County	Health Care and Social Assistance
137	BOC International	Baltimore County	Health Care and Social Assistance
138	CareFirst BlueCross BlueShield	Baltimore County	Finance and Insurance
139	Western Maryland Health System	Allegany County	Health Care and Social Assistance
140	Baltimore County Public Schools	Baltimore County	Educational Services
141	RCM&D	Baltimore County	Finance and Insurance
142	Greater Maryland Medical Center	Baltimore City	Health Care and Social Assistance
143	Hord Coplan Macht, Inc.	Baltimore City	Other Services (except Public Administration)
144	Kelly & Associates Insurance Group	Baltimore County	Finance and Insurance
145	G.1440	Baltimore City and Howard County	Professional, Scientific, and Technical Services
146	Anderson, Coe & King, LLP	Baltimore City	Professional, Scientific, and Technical Services

147	Health Care for the Homeless	Baltimore City	Health Care and Social Assistance
148	TBC Inc.	Baltimore City	Other Services (except Public Administration)
149	Transamerica Life Insurance Company	Baltimore City	Finance and Insurance
150	Novartis Pharmaceuticals	State-wide	Health Care and Social Assistance
151	Mt Washington Pediatric Hospital	Baltimore City	Health Care and Social Assistance
152	RSM McGladrey	Baltimore County	Professional, Scientific, and Technical Services
153	American Diabetes Association Maryland Office	Baltimore City	Health Care and Social Assistance
154	The Aspen Group, Inc.	State-wide	Professional, Scientific, and Technical Services
155	Grant Thornton	Baltimore City	Finance and Insurance
156	Bon Secours Baltimore Health System	Baltimore City	Health Care and Social Assistance
157	Audacious Inquiry	Howard County	Management of Companies and Enterprises
158	Baltimore City Community College	Baltimore City	Educational Services
159	Carroll Community College	Carroll County	Educational Services
160	Community College of Baltimore County (Dundalk)	Baltimore County	Educational Services
161	University of Maryland Baltimore	Baltimore City	Educational Services
162	PNC Bank	State-wide	Finance and Insurance
163	United Healthcare	State-wide	Finance and Insurance
164	Aetna	State-wide	Finance and Insurance
165	Calvert Memorial Hospital	Calvert County	Health Care and Social Assistance
166	Carroll Hospital Center	Carroll County	Health Care and Social Assistance
167	LifeBridge Health	Baltimore City and Baltimore County	Health Care and Social Assistance

168	University of Maryland School of Medicine	Baltimore City	Health Care and Social Assistance
169	Erickson Retirement Communities	State-wide	Real Estate and Rental and Leasing
170	City of Salisbury	Wicomico County	Public Administration
171	Kaiser Permanente	State-wide	Finance and Insurance
172	Maryland Hospital Association	Howard County	Health Care and Social Assistance
173	Carroll Chiropractic & Sports Injury Center	Carroll County	Health Care and Social Assistance

Healthiest Maryland Businesses- Supporting Organizations[2]

	Company	**Industry**
1	American Cancer Society	Health Care and Social Assistance
2	American Diabetes Association	Health Care and Social Assistance
3	American Heart Association	Health Care and Social Assistance
4	Bike Maryland	Health Care and Social Assistance
5	Calvert Memorial Hospital	Health Care and Social Assistance
6	COPD Foundation	Health Care and Social Assistance
7	Frederick County Health Department	Public Administration
8	Greater Baltimore Committee	Other Services (except Public Administration)
9	Healthy U Delmarva	Health Care and Social Assistance
10	Hospitals for a Healthier Environment	Health Care and Social Assistance
11	Howard County Health Department	Public Administration
12	Injured Workers Insurance Fund	Finance and Insurance
13	Kent County Health Department	Public Administration

[2] A Healthiest Maryland Businesses Supporting Organization is a worksite wellness partner with subject matter expertise that provides resources to Maryland employers.

14	MedStar St. Mary's Hospital	Health Care and Social Assistance
15	Maryland Cancer Collaborative	Health Care and Social Assistance
16	Maryland Department of Aging	Public Administration
17	Maryland Health Care for All! Coalition	Public Administration
18	Maryland Hospital Association	Health Care and Social Assistance
19	Maryland Recreation and Parks Association	Health Care and Social Assistance
20	Maryland P3 Program	Health Care and Social Assistance
21	MidAtlantic Business Group on Health	Other Services (except Public Administration)
22	National Committee for Quality Assurance	Health Care and Social Assistance
23	Partnership for Prevention	Health Care and Social Assistance
24	Partnership for a Healthier Carroll County	Health Care and Social Assistance
25	Small Business Majority	Other Services (except Public Administration
26	Western Maryland Health System	Health Care and Social Assistance
27	Wicomico County Health Department	Public Administration
28	Worcester County Health Department	Public Administration

Healthiest Maryland Businesses- Ambassadors[3]

	Company:	**Industry:**
1	Carefirst BlueCross BlueShield	Health Care and Social Assistance
2	Johns Hopkins	Health Care and Social Assistance
3	LifeBridge Health	Health Care and Social Assistance
4	Marriott International	Accommodation and Food Services

[3] A Healthiest Maryland Businesses Ambassador is a member organization of the Health Quality and Cost Council that is responsible for guiding and advising program efforts.

5	MedStar St. Mary's Hospital	Health Care and Social Assistance
6	Perdue Farms	Poultry Processing
7	University of Maryland School of Medicine	Educational Services

Meritus Health

A Healthiest Maryland Businesses Success Story

Employee-Led Wellness Works

Meritus Health is a health care system based in Hagerstown, with 3500 employees. Initially, the company had an employee wellness program that was activity oriented, but they wanted to go a step further and develop a results-oriented program. This was important because Meritus wanted data to support that their wellness programs were actually making a difference—not only for employees' health, but also for the organization's financial health. Their program was based on guidance from the Wellness Council of America (WELCOA). A wellness committee was formed to use these benchmarks to lay the foundation for a successful employee wellness program.

The first benchmark is to get CEO support. Meritus was fortunate to have a CEO who supported wellness and actually led by example. He is an avid cyclist, he requested lunch choices of 500 calories or less in the cafeteria, he parks his car in the far lot and "hikes" to work, and he signed the commitment for Meritus to be a Healthiest Business in Maryland. In addition, one of the company's vice presidents is also a member of the wellness committee.

Meritus Health's Gold Medal Employees: They participated in the Summer Olympic Challenge to exercise a minimum of 30 minutes a day for 5 days a week in an Olympic sport of their choice.

The second benchmark is to create a wellness team. According to WELCO, health promotion programs work best when employees are involved in the design, planning, promoting, delivering and managing of the program. This structure was helpful in creating a network of employees who could identify wellness issues throughout the health system. The committee members became Wellness Champions

Meritus at a Glance:

- Type of Business: Health Care System
- Location: Hagerstown
- Number of Employees: 3500
- What Worked: An employee-driven wellness program with multiple options for participation, specific objectives, and measurable results.
- Program Model: Wellness Council of America

attract the interest of coworkers. Management, as well as front-line employees from key departments, make up the company's 15-member wellness committee. An employee health management consultant is an ad-hoc member of the wellness team. Their involvement has helped in relationship building with employees. This element of trust is important as the consultant provides Meritus employees with health coaching services.

The third benchmark is to collect data to drive health efforts. Meritus offers a health risk assessment (HRA) as well as an employee wellness interest survey every two years. The HRA data is used in an employer summary report, which provides measurement of results and directs the committee's focus on the health issues that need addressed. Additionally, Meritus continually monitors their medical claims to aid in the strategic decisions necessary for appropriate interventions. Data scorecards are used to communicate the basic outcomes of an initiative to senior management.

The fourth benchmark is to create an operating plan. The team reviewed the data from the HRA and employee interest survey and formulated a five-year operating plan that included goals that would meet their employee's health needs. This assured that everyone was operating on the same page and gave the committee the focus it needed to proceed with meaningful initiatives. The committee reviews the operating plan every two years to see if modifications are needed, after the HRA and employee interest survey results are compiled.

Benchmark number five is to choose appropriate interventions. The HRA helped identify the top three areas of health concern for employees, and the interest survey identified the three top wellness interests of employees. The team committed to communicating, educating, participating and evaluating the five identified goals and their initiatives, which were based on employee fitness, weight reduction, resiliency, healthy lifestyles and smoking cessation. The team offered a variety of initiatives for each goal, to entice employees regardless of ability levels.

> *"There is still much to do, but having a great foundation and all the correct tools...has made all the difference."*

The sixth benchmark is to create a supportive environment. This was done in a variety of ways, such as healthy food choices in the vending machines and cafeteria, smoke-free campus, developing campus walking maps for employees, an on-site gym as well as contracts with neighboring gyms for employee membership discounts, etc. All employees are introduced to the wellness program at their orientation session.

The final benchmark is to evaluate outcomes. Baseline and follow-up data are compared to assess the interventions' impact on employees. Outcome data adds value to the program when it illustrates health benefits to employees and cost savings to the health system.

Spreading the word about successful programs boosts participation in other wellness initiatives. For example, a Biggest Loser contest had 65 participants. They had so much fun and success that 120 people signed up for the Healthy Wage weight loss program.

The Wellness Works Committee accomplished all of this in 2.5 years. There is still much to do, but having a great foundation and the correct tools—WELCO, THP, a wellness team, and senior management support—has made all the difference. The next goal is to find ways to maintain employee engagement, provide consistent motivation, and help employees strive toward personal wellness every day of their lives.