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 1, 2014

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 2013.

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.

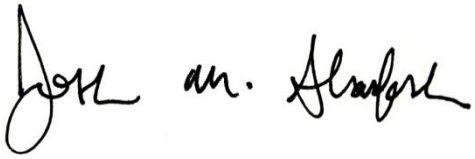
During the past year, the Council's workgroups have made significant progress in implementing key strategies to improve health in Maryland. In addition, each workgroup has been charged with incorporating strategies to address health disparities into every initiative. This report summarizes the Council's activities in 2013.

In 2014 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
Vice-chair, Maryland Health Quality and Cost Council

Enclosure

CC: Russ Montgomery
Ben Stutz
Patrick Dooley
Laura Herrera
Donald Shell
Carlessia Hussein
Ben Steffen
David Sharp

MARYLAND HEALTH QUALITY & COST COUNCIL

ANNUAL REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY

January 2014

The Honorable Anthony G. Brown
Lieutenant Governor

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

MARYLAND HEALTH QUALITY AND COST COUNCIL

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

Council Members

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 and 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

Nicolette Highsmith Vernick, M.P.A.
President and Chief Executive Officer, Horizon Foundation

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 and 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

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

Primary Staff

Russ Montgomery, M.H.S. (Director)
Policy Advisor, Public Health, Department of Health and Mental Hygiene

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

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

Donald Shell, M.D., M.A.
Director, Center for Chronic Disease Prevention and Control, Department of Health and Mental Hygiene

Blair Ennis, J.D., M.A.
Policy Analyst, Center for Chronic Disease Prevention and Control, Department of Health and Mental Hygiene

David Sharp, Ph.D.
Director, Center for Health Information Technology and Innovative Care Delivery, Maryland Health Care Commission

Sarah Orth, M.A.
Chief, Health Information Technology, Maryland Health Care Commission

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EXECUTIVE SUMMARY

The Maryland Health Quality and Cost Council (Council), established by an executive order form Governor Martin O'Malley in 2007, is tasked with providing 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 initiatives to improve the quality and reduce the costs of health care in Maryland. These efforts continue to complement the ongoing process to implement the Affordable Care Act in Maryland.

Wellness and Prevention. The Wellness and Prevention workgroup made substantial progress in fulfilling its mission of developing actionable wellness and prevention strategies to promote healthy lifestyles and improve health status. Healthiest Maryland is a 'grasstops' social marketing campaign that encourages leaders to promote wellness. The Healthiest Maryland Businesses initiative was launched as the cornerstone of the Healthiest Maryland campaign in 2010. Since then, over 230 companies have enrolled, representing 250,000 Maryland employees and covering 23 Maryland jurisdictions. Technical assistance on best practices is provided to these companies through direct consultation by certified worksite wellness specialists, regional events, and other programs.

Efforts to improve the health status of state employees were expanded. New in 2013, the Department of Health and Mental Hygiene and other state agencies partnered with the University of Maryland to implement the P3 initiative, offering comprehensive Medication Therapy Management to a pool of 5,000 state employees located in and surrounding the West Preston Street State Center Complex. These initiatives aim to improve health outcomes for employees participating in the pilot while showing cost savings for the state. In addition, the workgroup continues to promote the procurement of healthier food items by state agencies, and engaged in a scan of vending machines in 2013.

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 uses to identify and prioritize on-going Council activities.

Cultural and Linguistic Competency. In April 2012, Governor O'Malley signed a law that called for Council to convene a workgroup to examine standards for cultural and linguistic

competency in health care delivery. The three charges to the Workgroup are: 1) develop recommendations for cultural competency standards for medical and behavioral service settings, 2) recommend standards for multicultural health in Patient Centered Medical Homes (and other health care settings), and 3) propose standards for continuing education in cultural competency for health care providers. Council members Lisa Cooper and Marcus Pesquera serve as co-chairs, and forty-nine persons were appointed by the Secretary to serve on the workgroup.

Subcommittees were formed to work on each specific charge outlined in the law. From May to November, each subcommittee completed their draft recommendations, addressing each of the three charges. Workgroup staff developed the final report, which was submitted to the Secretary on December 1, 2013. This main body of the Cultural Competency Workgroup Report, including all recommendations, is included as an appendix.

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. Council member Peggy O'Kane, President of NCQA, is Chair of the EBM 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 increase utilization of high-value health services and reducing utilization of low-value services by adjusting cost-sharing. In 2013, experts from the University of Michigan developed a set of policy options for promoting VBID in the Maryland Health Benefits Exchange and self-insured employers in Maryland. The Council passed a motion to create the Value Based Insurance Design Task Force to make recommendations on appropriate health care services for cost-sharing adjustments and to select policy options from those developing by the experts. This task force will be convened in 2014.

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 2013, penetration of appropriate hand hygiene methods reached new highs, with an average of 87 percent compliance across all hospitals.

Telemedicine Task Force. In 2013, the Maryland General Assembly passed a law requiring the Maryland Health Care Commission, in collaboration with the Council, to reconvene the Telemedicine Task Force to study the use of telehealth throughout the State. A report is due to the Governor and General Assembly by December 1, 2014 that includes recommendations aimed at increasing the use of telemedicine. Specifically, the report must identify opportunities to use telehealth to improve health status and care delivery in the State, assess factors related to use of telehealth, and identify strategies for telehealth deployment in rural areas of the state. To address these issues, three advisory groups were formed: Clinical Advisory Group, Technology Solutions and Standards

Advisory Group, and Finance and Business Model Advisory Group. These groups began meeting in mid-2013, and will continue meeting in 2014 to develop recommendations for the report.

Health Disparities. Lt. Governor Anthony Brown, Council Chair, championed the Health Enterprise Zone program as a critical strategy for improving health status, reducing health disparities, and lowering health care costs in areas of Maryland with poor health outcomes and high rates of poverty. In 2012, the General Assembly passed Senate Bill 234, which authorized the program based on the recommendations of the Health Disparities Workgroup, led by Council member E. Albert Reece, Dean of the University of Maryland School of Medicine. The law established a competitive process to designate HEZs.

Of 19 submissions, five Zones were named in 2013 in the following jurisdictions: Annapolis, Dorchester and Caroline Counties, Capitol Heights in Prince George's County, Greater Lexington Park in St. Mary's County, and West Baltimore. All of the selected Zones have specific interventions targeted at chronic conditions such as cardiovascular disease, hypertension, and asthma. Implementation of the Zones is ongoing, and efforts at the state-level are focused on providing technical assistance to support implementation and developing performance monitoring to assess the impact of the interventions.

INTRODUCTION AND BACKGROUND

Council's Establishment and Purpose

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

The Council is tasked with providing 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 thirteen 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 includes 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.

Nicolette Highsmith Vernick, M.P.A. represents the voice of consumers on the Council. Ms. Highsmith Vernick is President and Chief Executive Officer of the Horizon Foundation, an independent philanthropy focused on improving health and wellness in Howard County and state-wide.

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 President of Sibley Memorial Hospital, a Johns Hopkins Medicine hospital in the District of Columbia, and a noted expert in patient safety in acute care settings. 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;
- Develop actionable strategies to improve access and decrease health disparities for Maryland's minority populations;
- Explore the current state of telemedicine in Maryland, and study the feasibility of expanding telemedicine services across the state; and
- Develop and implement a strategy for incentivizing the use of high value health care services in health insurance plans.

Wellness and Prevention Workgroup

The Wellness and Prevention Workgroup is charged with developing actionable wellness and prevention strategies that fulfill the Council's 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 by increasing access to healthy food, being physically active, and adhering to recommended preventive screenings and treatment, to decrease the prevalence of chronic disease, and ultimately increase life expectancy and health equity in Maryland. Significant progress was made in 2013 towards achieving these goals.

The Workgroup's activities are structured to align and support 11 health objectives related to wellness and prevention strategies, as defined by the Maryland State Health Improvement Process (SHIP), including:

1. Increase access to healthy foods (Objective 18);
2. Reduce deaths from heart disease (Objective 25);
3. Reduce diabetes-related emergency department visits (Objective 27);
4. Reduce hypertension-related emergency department visits (Objective 28);
5. Increase the proportion of adults who are at a healthy weight (Objective 30);

6. Reduce the proportion of children and adolescents who are considered obese (Objective 31);
7. Reduce the proportion of adults who are current smokers (Objective 32);
8. Reduce the proportion of youths who use any kind of tobacco product (Objective 33);
9. Reduce the proportion of hospitalizations related to Alzheimer's disease and other dementias (Objective 35);
10. Increase the proportion of adolescents who have an annual wellness checkup (Objective 37); and
11. Increase the proportion of children and adolescents who receive dental care (Objective 38).

Initiative 1: Healthiest Maryland

Healthiest Maryland is a grasstops movement engaging leadership in communities, schools, businesses, and health care 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 Communities, Healthiest Maryland Schools, Healthiest Maryland Businesses, and Healthiest Maryland Health Care. Healthiest Maryland Businesses was prioritized by the Council 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 movement. 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 programs that promote total worker health are given special recognition.

Recruitment. To date, 238 companies have enrolled and made an organizational commitment (see Appendix B for a list of participating companies, supporting organizations, and ambassadors). Participating companies are located in 23 Maryland jurisdictions and reach over 250,000 full-time Maryland employees.

Referral. A preliminary evaluation of HMB reported that Maryland companies need technical assistance and diverse trainings to make sustainable changes at the workplace. Given the increasing demand for comprehensive workplace wellness programs and local expertise, HMB programmatic enhancements have focused on providing more

comprehensive technical assistance and trainings to employers through a regional approach. Specific HMB technical assistance and training activities include:

- Planning, promoting, and conducting regional HMB sponsored events (e.g Health Reform/Healthy Business Forums, Regional Forums) and collaborating with partners to provide additional 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, program matrix of recommended strategies, and issue specific publications;
- Capturing successes and developing a "library" of program stories;
- Promoting relevant wellness opportunities (e.g. events, webinars, publications, funding) to participants, through email; and
- Implementing a HMB Regional Coordinator pilot project on the Mid-Eastern Shore to provide local outreach and technical assistance.

A success of these technical assistance efforts is the addition of five new HMB Regional Coordinators. The CDC recently expanded the support for provision of enhanced direct technical assistance to employers and increased opportunities for peer-to-peer learning within the five new HMB regions – Western, Capital, Southern, Central, and Lower Eastern Shore (See Appendix B). This regional approach will provide a multitude of benefits to employers including: helping worksites to implement recommended food service guidelines (in alignment with the USDA Dietary Guidelines); instituting opportunities for employees to become active; implementing value-based insurance design principles; promoting utilization of chronic disease self-management education programs to employees; and providing breastfeeding-friendly environments in worksites.

Recognition. Recognition efforts have been expanded to highlight worksite wellness success stories in the Department's quarterly newsletter and monthly email messages. This project features a Maryland employer with a successful or unique wellness program that aligns with CDC supported systems and environmental worksite changes. Please see Appendix C for examples of current HMB Success Stories.

Next Steps. The Wellness and Prevention Workgroup's ongoing efforts for 2014 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, and developing a framework to recognize participants.

Initiative 2: 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 a program be created to design and implement this healthy practice along with other comprehensive wellness programs on a broader scale.

State Government Food Procurement Workgroup

Made up of key state agencies—Departments of Aging, Education, General Services, Health and Mental Hygiene, Juvenile Services, Public Safety, and Corrections—the food procurement workgroup was convened for the first time in September 2012. This group discussed the results of the state agency food environment assessment and the U.S. Health and Human Services/ General Services Administration Health and Sustainability Guidelines for Federal Concessions and Vending.

Next Steps. Currently, there is an ongoing nutritional scan of state and local health department vending machines. These results will be evaluated and the results will be shared with the Food Procurement Workgroup, with the goal of expanding the nutritional scan to other Maryland agencies and using these results to promote healthier vending options in these agencies.

State of Maryland Medication Therapy Management pilot

In 2013, the Departments of Health and Mental Hygiene and Budget and Management collaborated with the University of Maryland, Baltimore to implement the P3 initiative offering Medication Therapy Management (MTM) and Comprehensive MTM Services to a pool of 5,000 state employees located in and surrounding the West Preston Street State Center Complex. The P3 initiative is collaborating with the Department of Budget and Management, Express Scripts, and State employee insurance providers to improve health outcomes for employees participating in the pilot while showing cost savings for the State.

Next Steps. The pilot will continue until June, 2014. After the conclusion of the pilot, an evaluation report will be produced, showing the reach, participation, employee health outcomes, and potential cost savings. The Department of Budget and Management will evaluate this report and use it as a reference for designing future employee benefits.

Partnership with the CDC Work@Health™ Initiative
In 2013, HMB agreed to partner with the national Centers for Disease Control and Prevention (CDC) on its Work@Health™ initiative. Work@Health™, is an employer-based workplace training to improve the organizational health of participating employers, with an emphasis on strategies to reduce chronic disease and injury risk, and improve overall worker productivity. HMB will gain access to national worksite health data, as well as Maryland statewide and countywide data that will assist in HMB growth and development of new, relevant programs.

Next Steps. Work@Health has just completed its pilot phase and is in the process of collecting data across the country. Once available, program results and employer feedback will be shared with HMB, and the curriculum for the employer-based workplace training will be updated based on the results. The training for the Eastern region will take place in Baltimore City. HMB will invite all employers throughout the state of Maryland to attend.

Initiative 3: Million Hearts Campaign
The Council supports 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. The Council's Million Hearts 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.

Cultural Competency Workgroup

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the Council to form the Cultural Competency Workgroup to explore and make recommendations on how the state could increase the cultural, linguistic, and health literacy competency of health providers and health care delivery organizations throughout Maryland. The three charges to the Workgroup are: 1) develop recommendations for cultural competency standards for medical and behavioral service settings, 2) recommend standards for multicultural health in Patient Centered Medical Homes (and other health care settings), and 3) propose standards for continuing education in cultural competency for health care providers. Forty-seven persons were appointed to serve on the Workgroup, a team of twelve volunteered in the Staff Support Group, and oversight was provided by the Office of Minority Health and Health Disparities in partnership with the Maryland Health Care Commission.

Progress to Date

The first meeting of the Workgroup was held on November 29, 2012. The Co-Chairs covered the charge to the workgroup, an overview of SB 234 and the MHQCC, and a draft work plan. Each of the three Workgroup Charges were presented and discussed, in detail. Members were asked to submit input on the work plan and to identify the Subcommittee/Charge in which they would like to participate. Workgroup staff were asked to consider coordinating a Cultural Competency presentation to ensure that all Workgroup members had a similar level of understanding.

From November 2012 through January 2013, Workgroup Staff coordinated the Subcommittee assignments and Subcommittee Leaders, and assisted Subcommittee Leaders in the coordination of the communication exchanges with the Subcommittee members. Through electronic and teleconference, each Subcommittee developed a preliminary work plan. An expert in Cultural and Linguistic Competency training, Ms. Darci Graves of SRA, International, Inc. was identified as the Cultural Competency presenter for the following meeting.

The second Workgroup meeting, held on January 23, 2013, included a presentation and discussion on issues surrounding Cultural Competency from Ms. Darci Graves, SRA, International, Inc. Dr. Carlessia Hussein with the Office of Minority Health and Health Disparities presented the Workgroup Subcommittee process, staff, members, and expectations. Following the full Workgroup discussion, each Subcommittee broke out for a work session. Subcommittee Charge 1 was co-lead by Yolanda Ogbolu and Scharmaine Robinson, Subcommittee Charge 2 was co-lead by Thomas LaVeist and Earl Ettienne, and Subcommittee Charge 3 was co-lead by Linda Aldoory and Daniel Teraguchi. Members were asked to continue working with their Subcommittees and making progress on the assigned charges. From January through May, each Subcommittee coordinated their work through electronic means and teleconference. Workgroup staff followed up with each workgroup and ensured that progress was being made toward the deadlines.

The third Workgroup meeting, held on May 14, 2013, included a Subcommittee report-out and discussion. Subcommittee Charge 1 was presented by Yolanda Ogbolu and Scharmaine Robinson, Subcommittee Charge 2 was presented by Cheri Wilson (on behalf of Thomas LaVeist) and Earl Ettienne, and Subcommittee Charge 3 was presented by Linda Aldoory and Daniel Teraguchi. Following the full group discussion, each Subcommittee broke out for a work session. Members were asked to have their Subcommittee draft recommendation submitted by June 15.

From May to November, each Subcommittee completed their draft recommendations document, addressing each of the three charges. Once submitted, Workgroup staff

reviewed the initial reports, requested clarifications, and developed the final report. The report was submitted to the Secretary on December 1, 2013, and is included in this Annual Report as Appendix D.

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.

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, Kathleen White, Roger Merrill, and Nicolette Highsmith Vernick.

The workgroup generally holds conference calls between quarterly Council meetings. The calls include an update on ongoing projects and any interventions necessary to keep them on track. The two primary initiatives of the Workgroup in 2013 are Value-Based Insurance Design and the Hand Hygiene Collaborative.

Initiative 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.

The Workgroup began pursuing value-based insurance design (VBID) as a new strategy for health plan design in 2012. VBID is an innovative solution to maximizing health outcomes with available health care dollars. The basic premise of VBID is to align consumer incentives and payment strategies with value by reducing barriers to high-value health services and providers ("carrots") and discouraging the use of low-value health services and providers ("sticks"). When carrots and sticks are used in a clinically nuanced manner, VBID improves health care quality and controls spending growth. The concept of clinical nuance recognizes that: 1) medical services differ in the benefit provided; and 2) the

clinical benefit derived from a specific service depends on the patient using it, as well as when and where the service is provided.

The primary objectives of a VBID program are:

- Obtain the greatest positive health impact from medical expenditures.
- Shift the focus of the health care debate away from cost alone to also include the clinical value of health services by restructuring health benefits and payment policies.
- Minimize the lack of adherence to evidence-based services that may result from across-the-board increases in cost sharing levels.

Carrot VBID programs reduce cost sharing for services that have strong evidence of high clinical value—typically primary preventive services and treatments for chronic diseases. Multiple peer-reviewed studies demonstrate improved clinical outcomes in VBID incentive programs.

Experts from the University of Michigan prepared a white paper reviewing successful VBID programs and proposed a strategy for the Workgroup's consideration. The paper highlighted a set of policy options for promoting VBID in Maryland and a public process to designate services most appropriate for VBID. The Council was presented the initial policy options in September 2014 and felt that the options were worthy of detailed consideration by a larger panel. The Council passed a motion to create the Value Based Insurance Design Task Force to designate services and recommend individual policy options for promoting VBID in both health plans in the Maryland Health Benefits Exchange and self-insured plans. This work will commence in early 2014.

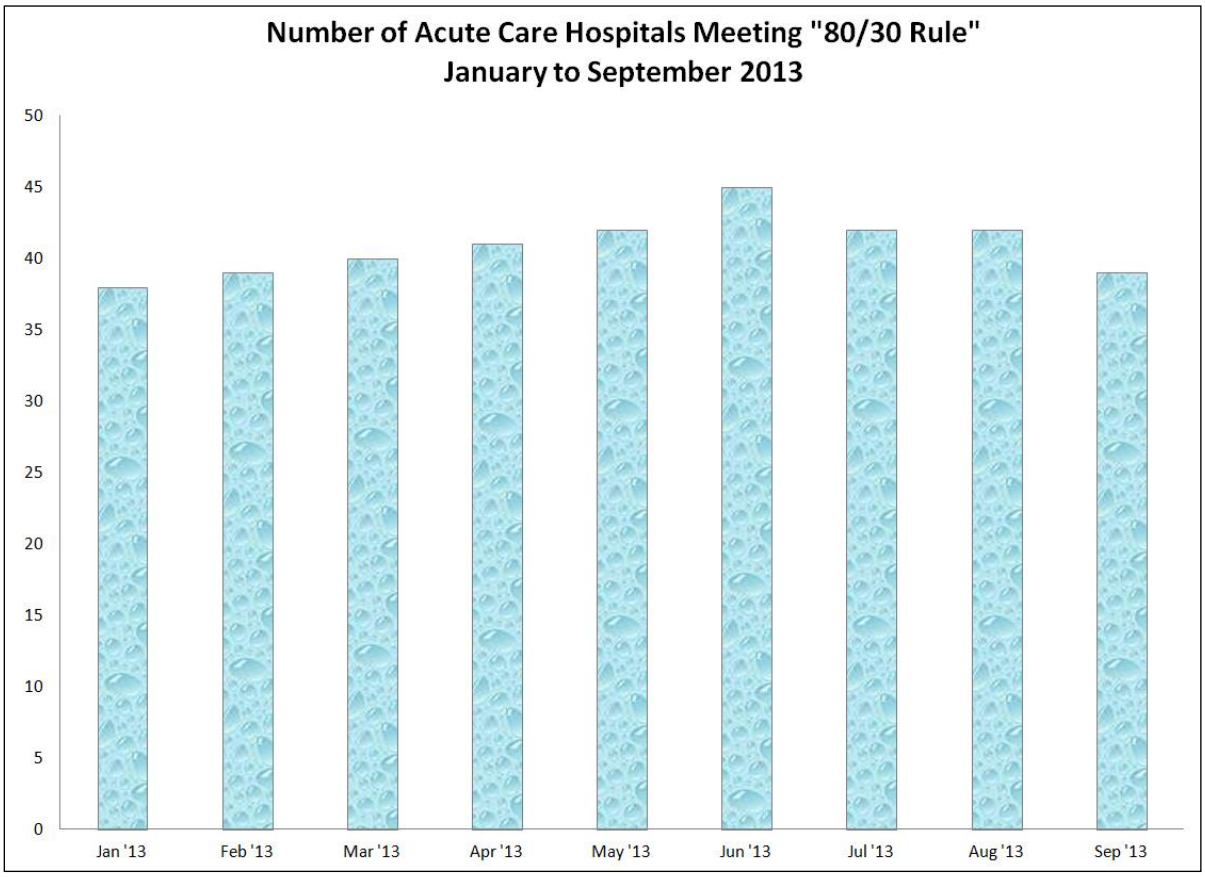
<u>Initiative 2</u>: Maryland Hospital Hand Hygiene Collaborative

The Maryland Hospital Hand Hygiene Collaborative (Collaborative) began in 2010 with the goal of reducing preventable infections through better hand hygiene. The Collaborative is a voluntary, statewide effort led and administered by the Maryland Patient Safety Center (Center) with support from the Maryland Hospital Association (MHA) 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 percent of their required units reporting with 30 or more observations; this is known as the "80/30 Rule."

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. As a result of this responsive and high-visibility approach, participation and performance in the Collaborative is at an all-time high.

As Figure 1 illustrates, the number of hospitals meeting the 80/30 Rule remains high, with 100 percent of participating hospitals meeting this standard for the first time in June 2013. Hand hygiene compliance continues to improve as well, with an average compliance rate of 87 percent, as illustrated in Figure 2. This improvement is a result of extensive progress across the Collaborative as a whole. There were 30 hospitals consistently meeting a minimum of 85 percent compliance in September 2013, compared to 12 in January 2012.

Figure 1: Number of Maryland Acute Care Hospitals meeting the "80/30 Rule"



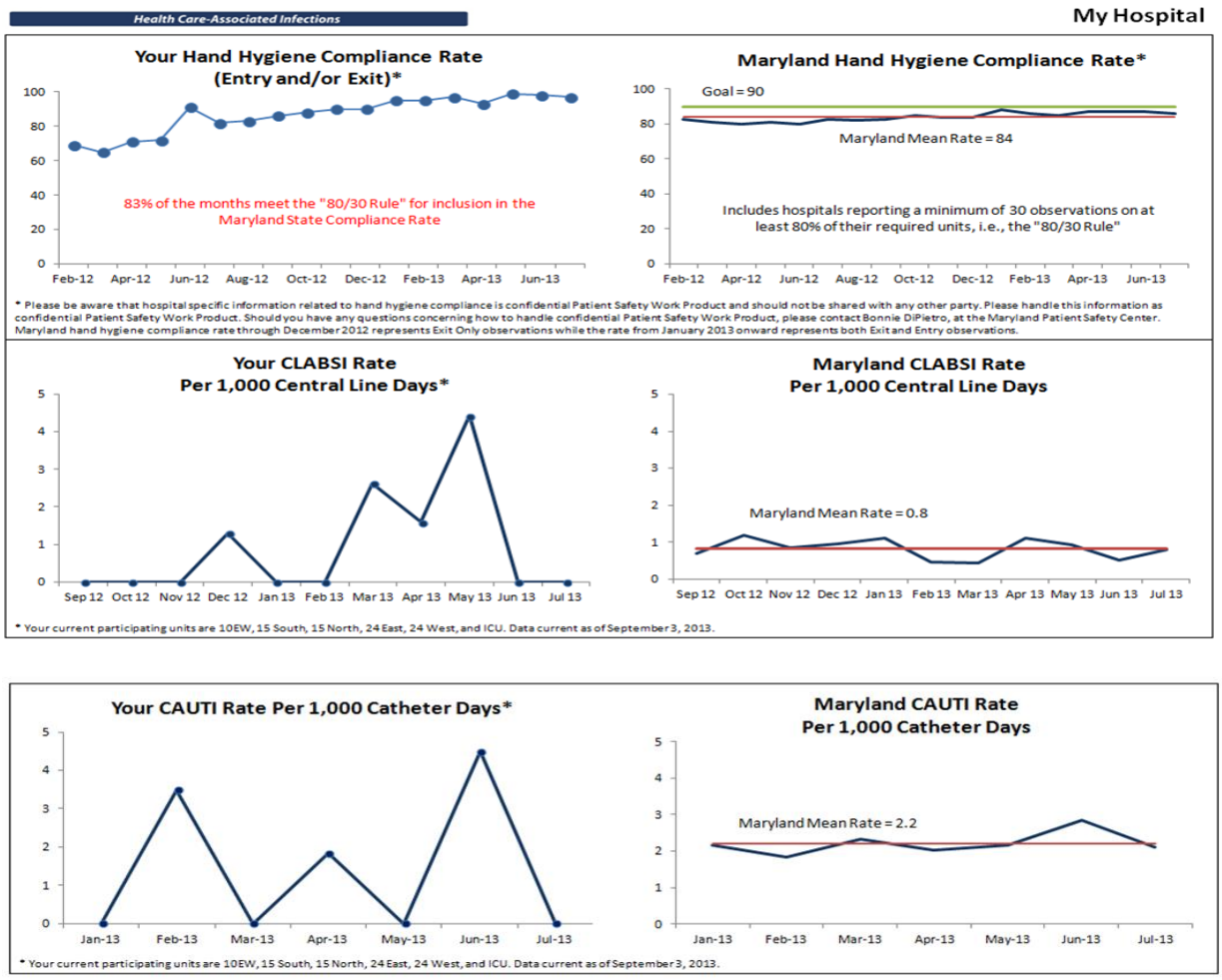
In addition, the Center, in partnership with the Maryland Hospital Association:

- 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) that are distributed to hospital CEOs and infection preventionists each month (see Figure 2);
- Created infection dashboard reports that are distributed to hospital CEOs on a quarterly basis to illustrate associations between hand hygiene compliance and MHA's hospital-specific infection data (see Figure 3); and
- Created a monthly hand hygiene update report to DHMH.

Figure 2: Sample Monthly Performance Report for Hospital CEOs and Infection Preventionists

Maryland Hospital Hand Hygiene Collaborative Report Card					
Hospital A					
	YOUR ORGANIZATION				MD STATE COLLABORATIVE
	Inclusion in the State Compliance Rate Report- "80/30 rule"	# Required Units	# Required Units with 30 observations (Exit and/or Entry)	Your organization's Hand Hygiene Compliance Rate (Exit and/or Entry)	Maryland's Hand Hygiene Compliance Rate (Exit & Entry)
2013					
September	Yes	9	9	92	87
August	Yes	9	9	82	86
July	Yes	9	9	79	86
June	Yes	9	8	84	87
May	Yes	9	8	90	87
April	Yes	9	9	90	87
March	Yes	9	9	92	85
February	Yes	9	9	89	86
January	Yes	9	9	97	88

Figure 3: Sample Quarterly Infection Dashboard for Hospital CEOs



This reporting has continued throughout 2013. In addition, the Center developed and transitioned users to their own data platform to receive hand hygiene compliance data from hospitals in January 2013. This change has reduced user error and dissatisfaction by providing timely technical support and implementing a series of upgrades requested by users to provide improved tracking of performance by hospital teams.

Throughout 2014 the Center will continue to work to reach the Collaborative goal of 90 percent compliance by continuing targeted technical assistance and regional site visits in an effort to meet with every hospital's team lead. They will also look to expand reporting into the Emergency Department as well as explore piloting the project in long term care facilities. Discussions with the two long term care associations, Health Facilities of Maryland (HFAM) and LifeSpan are underway.

Telemedicine Task Force

Maryland law required the Maryland Health Care Commission (MHCC), in coordination with the Council, to reconvene the Telemedicine Task Force to study the use of telehealth throughout the State.[1,2] The law also requires MHCC to update the Governor, Senate Finance Committee, and the House Health and Government Operations Committee on the work of the task force by the end of 2013. The final report, due to the Governor and General Assembly by December 1, 2014 will include recommendations aimed at increasing the use of telemedicine. The law became effective on July 1, 2013 and requires the task force to:

- Identify opportunities to use telehealth to improve health status and care delivery in the State, including an analysis of underserved population areas, applications for cost-effective telehealth, innovative payment models, and innovative service models for diverse care settings including chronic and acute care
- Assess factors related to telehealth, including an analysis of public and private grant funding; emerging technology and standards for security; health professional productivity, resources, and shortages; supportive uses of electronic health records and health information exchange; and multimedia uses of products and services for patient engagement, education, and outcomes
- Identify strategies for telehealth deployment in rural areas of the State to increase access to health care and meet any increased demand for health care due to the implementation of the Patient Protection and Affordable Care Act
- Study any other topic MHCC finds necessary to make recommendations regarding use of telehealth in the State

Progress to Date

The task force consists of three advisory groups: Clinical Advisory Group, Technology Solutions and Standards Advisory Group, and Finance and Business Model Advisory Group. The task force reconvened in a joint session of all three advisory groups on July 24, 2013. From August through November 2013, the Clinical Advisory Group and the Technology Solutions and Standards Advisory Group convened approximately once per month. As the work of the Clinical and Technology Solutions and Standards Advisory Groups advances, the Finance and Business Model Advisory Group will reconvene in early 2014.

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[1] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

[2] Telemedicine, as defined in Maryland law, means the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.

The task force discussed exploring opportunities to advance telemedicine in Maryland with an emphasis on expanding use in innovative care delivery models. The advisory groups have been assessing methods for using telemedicine to increase access to health care, improve patient outcomes, and reduce health care costs. The Clinical Advisory Group discussed clinical use cases for telemedicine that have the potential to improve health outcomes while containing costs. Potential areas of telemedicine deployment were also discussed. The Technology Solutions and Standards Advisory Group explored the development of a telemedicine provider registry (registry) that could be accessed through the State-Designated health information exchange. The registry would allow providers to learn about other providers who are engaged in telemedicine and make connections with others delivering telemedicine services. In 2014, the Task Force will continue exploring the role of telemedicine in health care delivery and develop recommendations to expand telemedicine in Maryland.

Health Disparities Workgroup

The Health Disparities Workgroup was charged with exploring and developing health care strategies and initiatives, including financial, performance-based incentives, to reduce and eliminate health disparities, and making recommendations regarding the development and implementation of those strategies. With the Health Enterprise Zone initiative in the implementation phase, DHMH and the Community Health Resources Commission are providing leadership of this initiative, with additional oversight and advice provided by the Council.

<u>Initiative 1</u>: 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.

Designated Zones

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 series of public meetings were held across Maryland over the summer of 2012 to describe the opportunity, encourage applications, and answer questions. DHMH and the CHRC released the HEZ Call for Proposals on October 5, 2012. The CHRC received 19 submissions, and HEZ designations were made in December 2012.

The HEZs vary considerably in terms of geography, strategy, and use of incentives. All of the selected Zones have specific target clinical conditions such as cardiovascular disease rates, hypertension, and asthma (see Table 2). The annual budgets of these first five Zones range from $200,000 to $1.25 million, and activities are implemented by diverse coalitions that range in size of membership (from 4 to 16) and include local health departments, Federally Qualified Health Centers, a mobile mental health crisis team, local community hospitals, tertiary medical centers, Area Health Education Centers, an Historically Black College/University, a school of public health, a graduate university, local health improvement coalitions, and many community-based organizations/coalitions.

Figure 4. Five Designated Health Enterprise Zones

Anne Arundel County/Annapolis. The centerpiece of the suburban HEZ in Annapolis is the creation of a new health center embedded in the Morris Blum facility, a senior citizen public housing complex with high rates of emergency room utilization, hospital admissions and readmissions, and a large volume of medical 911 calls attributed to a lack of primary care. The building is a "hot spot" whose 184 elderly and disabled residents experience crisis-driven, episodic, and fragmented healthcare. In six months, 73 residents experienced 175 emergency room visits, with 38 of those resulting in admissions. The leading primary diagnoses for admissions were related to cardiac, pulmonary, or gastrointestinal disorders.5 The goal of the HEZ is to reduce diabetes-related and smoking illness, obesity, and cardiovascular disease of the Morris Blum residents. The center is now fully staffed with one physician, one registered nurse/case manager, and two medical office assistants and began providing services in October 2013.

Dorchester and Caroline Counties. This rural HEZ seeks to improve public health outcomes in Dorchester and Caroline County, two jurisdictions that demonstrate high rates of emergency department visits due to diabetes, hypertension, and behavioral health issues. Dorchester County suffers from a rate of behavioral health ED visits twice as high as the state average. Since all but one of the publically funded mental health clinics on Maryland's Eastern Shore were closed over a decade ago, resources for behavioral health have been sparse and inaccessible for individuals most at need. The Zone has a particularly strong focus on improving behavioral health support and has created a new mobile mental health crisis team that provides behavioral health crisis intervention, assessment, and referral services. The Zone has also expanded school-based primary and behavioral health

services, as HEZ funds were utilized to hire a new pediatric nurse who is also certified in pediatric behavioral health.

Prince George's County Health Department/Capitol Heights. This suburban HEZ focuses on Capitol Heights, a community with a lack of primary care providers. The goal of the HEZ is to create five new patient-centered medical homes (PCMHs) to serve 10,000 residents over the four-years of the program. The Zone seeks to improve primary care provider-to-patient ratios and to reduce hospital admissions and readmissions for asthma, diabetes, and cardiovascular disease. The first site, a Federally Qualified Health Center, expanded capacity by hiring four additional physicians and two part-time nurse practitioners and is currently seeing patients. Locations for the next two future PCMHs have been finalized, and physicians have been identified to practice at these new sites. Both of these sites are expected to begin providing health care services by the end of 2013.

St. Mary's County/Greater Lexington Park. This rural HEZ seeks to improve health outcomes by reducing risk of cardiovascular disease, diabetes related illness in St. Mary's County, an area of the state with a dearth of primary care physicians. The goal of this HEZ is to expand access to primary and behavioral health services and to reduce emergency department and hospital admissions for key conditions as hypertension, asthma, pulmonary disease, heart failure, and diabetes. The Zone will utilize HEZ funds to create a new "health care transportation route" to link underserved residents experiencing transportation barriers in accessing services, establish a new community health center, and attract new practitioners to the Zone. In addition, the Zone is increasing the hours of operation of a local practice to integrate the delivery of primary care and behavioral health services and is adding culturally competent medical home services (e.g., case management, nutrition counseling, and chronic disease management).

West Baltimore. This urban HEZ focuses on a West Baltimore community that faces some of the highest disease burden rates, worst social determinants of health, and most persistent health disparities recorded by the Baltimore City Health Department over the last decade. 6 The West Baltimore Primary Care Access Collaborative seeks to reduce cardiovascular disease prevalence, obesity, and smoking and diabetes related illness, increase numbers of primary care and community health professionals, and decrease preventable hospitalizations and emergency department visits. Current activities include promoting access to affordable, healthy food options by co-sponsoring a Virtual Supermarket Program, a program that allows residents of the Zone to purchase groceries electronically with supermarkets participating in the program. The Zone also uses HEZ funds to promote resident engagement and has awarded community development grants to encourage community physicians to work with patients to adopt healthier lifestyles and promote workshops that promote physical activity and healthy eating habits for youth ages 8-18.

Monitoring Performance and Assessing Impact

The initial five HEZs will be closely monitored and independently evaluated. Monitoring will occur through site visits, grant reports, and a quarterly dashboard of process and outcome metrics that are based on national standards such as National Quality Forum and Uniform Data System measures.

The Act requires the Department and the Commission to submit an annual report to the Governor and Maryland General Assembly that includes: (1) number and types of incentives utilized in each HEZ; (2) evidence of the impact of tax and loan repayment incentives in attracting practitioners to the HEZs; (3) evidence of the impact of incentives offered in HEZs in reducing health disparities and improving health outcomes; and (4) evidence of the progress in reducing healthcare costs and hospital admissions and readmissions in HEZs.

There will also be independent evaluation. In July 2013, the Department of Health and Mental Hygiene and the Community Health Resources Commission issued a call for public comment on how best to evaluate both the impact of individual HEZs and the success of the overall initiative on the population of the HEZs. The evaluation is expected to begin in the first quarter of 2014 and will conclude after the duration of the program (end of calendar year 2016).

Additionally, the state is working with each of the five HEZs to implement sustainability plans to support the activities once the four-year pilot program concludes. These strategies include exploring the means to identify reductions in hospital admission and readmission costs and redeploying the savings that are achieved to support long-term program sustainability.

APPENDICES

Appendix A: Workgroup Meeting Dates and Participants

Wellness and Prevention Workgroup

Council Members
Christine Wray (Chair)
E. Albert Reece
James S. Chesley
Jon Shematek
Peggy O'Kane
Roger Merrill

Staff
Blair Ennis, DHMH
Donald Shell, DHMH
Tara Snyder, DHMH

Meeting Dates
January 31, April 25, July 25, and October 31

Cultural and Linguistic Competency Workgroup

Council Members
Lisa A. Cooper (Co-Chair)
Marcos Pesquera (Co-Chair)

Subcommittee 1
Yolanda Ogbolu, University of Maryland School of Nursing (Co-Chair)
Scharmaine Robinson, Maryland Health Care Commission (Co-Chair)
Thomas E. Arthur, Thomas E. Arthur and Associates
Maria S. Gomez, Mary's Center
Jerry Howard, II, The Maryland Center, Bowie State University
Senator Verna Jones-Rodwell, Maryland General Assembly
Yemisi (Oluyemisi) Koya, Maryland Board of Physicians
Betty Lam, Montgomery County Health and Human Services
Austria Lavigne Hooks, Aetna U.S. Healthcare Patient Management
Susan Leggett-Johnson, Kaiser Permanente
Sonia Mora, Latino Health Initiative, Suburban Maryland Welcome Back Center

Philip Osteen, University of Maryland, Baltimore School of Social Work
Carol Reynolds - Freeman, Potomac Physicians, P.A.
William Talley, Univ. of MD Eastern Shore School of Pharmacy and Health Professions
Kima Joy Taylor, Open Society Foundation
Fredette West, African American Health Alliance
Aerlande Wontamo, Lutheran Social Services of the National Capital Area
Sherman Yen, Asian American Anti-Smoking Foundation

Subcommittee 2
Thomas LaVeist, Hopkins Center for Health Disparities Solutions (Co-Chair)
Earl Ettienne, Howard University College of Pharmacy (Co-Chair)
Salliann Alborn, Maryland Community Health System
Cyntrice Bellamy-Mills, Department of Health and Mental Hygiene
Roger S. Clark, Medical Home Development Group
Florence Veronica Deza, MedStar Franklin Square Medical Center
Wendy Friar, Holy Cross Hospital
Dianne Houston-Crockett, Amerigroup Maryland, Inc.
Anna Maria Izquierdo-Porrera, Care For Your Health, Inc.
Niharika Khanna, Maryland Learning Collaborative
Sandra Kick, Maryland Women's Coalition for Health Care Reform
Ligia Peralta, University of Maryland Baltimore School of Medicine
Cheri Wilson, Hopkins Center for Disparities Solutions

Subcommittee 3
Linda Aldoory, University of Maryland School of Public Health (Co-Chair)
Daniel Teraguchi, Johns Hopkins School of Medicine (Co-Chair)
Brandon Batiste, Johns Hopkins Medicine
Janice Berry-Edwards, Howard University School of Social Work
Olivia Carter-Pokras, University of Maryland College Park School of Public Health
E. Keith Colston, Maryland Commission on Indian Affairs
Doris Dzameshie, African Immigrants and Senior Citizen Institute
Columbus Giles, Delmarva Foundation for Medical Care
Larry Gourdine, Monumental City Medical Society
Leslie Grant, Maryland State Board of Dental Examiners
Cheryl Jones, Chesapeake Regional Information System for Our Patients (CRISP)
Chimene Liburd, Maryland Chapter of the American College of Physicians
Yolanda Maria Welch Martinez, Governor's Commission on Hispanic Affairs
Monica McCann, Department of Health and Mental Hygiene
Lorraine W. Smith, Hygiene Board Examiners of Psychologists
Mohammed Younus, Psychiatrist, Catholic Charities, Johns Hopkins Hospital

Staff Support Group
Margot Aronson, Maryland Clinical Social Work Coalition
Eileen Dombo, Visiting Assistant Professor, Catholic University School of Social Service
Judith Gallant, Co-Chair, Maryland Clinical Social Work Coalition, Private Practice
Katherine Garcia, of Maryland College Park School of Public Health
Darci Graves, SRA International, Inc.
Cynthia Harris, Howard University School of Social Work and NASW-DC Metro
Laurie Hedlund, Frederick Community College
Steven Ragsdale, Connecting the Dots
Angel Shannon, University of Maryland
Ray Winbush, Institute for Urban Research, Morgan State University

Staff
Carlessia Hussein, DHMH
Kim Hiner, DHMH
Monica McCann, DHMH
Erin Dorrien, MHCC

Meeting Dates
January 23 and May 14

Evidence-Based Medicine Workgroup

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

Staff
Russ Montgomery, DHMH
Laura Herrera, DHMH
Lucy Wilson, DHMH

Meeting Dates
March 14 and November 18

Telemedicine Task Force

Clinical Advisory Group
Robert Bass (Chair), Maryland Institute for Emergency Medical Services Systems
Jillian Aldebron, Public Policy Partners
Eric Aldrich, Howard County General Hospital
Peter Antall, American Well Systems
Anna Aycock, Maryland Institute for Emergency Medical Services Systems
Andrew Barbash, Holy Cross Hospital
Dolores Branch, Sheppard Pratt Health System
David Brennan, MedStar Institute for Innovation
Lori Brewster, Wicomico County Health Department
Gary Brown, Office of Senator Catherine Pugh, Maryland General Assembly
Gary Capistrant, American Telemedicine Association
Patrick Carlson, Maryland General Assembly
Ernest Carter, Prince George's County Department of Health
Les Chalmers, CareFirst BlueCross BlueShield
Michelle Green Clark, Maryland Rural Health Association
Carlton Curry, Board of Physical Therapy
Michael Franklin, Atlantic General Hospital
Mitra Gavgani, Maryland Board of Pharmacy
Barbara Goff, Maryland Institute for Emergency Medical Services Systems
Frederick Harrison, WilHar Consulting LLC
Carole Hawkins, MedStar Franklin Square Medical Center
Zereana Jess-Huff, ValueOptions - Maryland
B. Tilman Jolly, Specialists On Call, Inc.
Bonnie Katz, Sheppard Pratt Health System
Mary Kraynak, Kaiser Permanente
Robert Kritzler, Johns Hopkins HealthCare LLC
Susan Lee, Maryland House of Delegates
Monty Magee, Maryland Institute for Emergency Medical Services Systems
Mary Mussman, Department of Health and Mental Hygiene
Kristen Neville, Department of Health and Mental Hygiene
Mimi Novello, MedStar Franklin Square Medical Center
Laura Pimentel, American College of Emergency Physicians
David Pruitt, University School of Medicine
Senator Catherine Pugh, Maryland General Assembly
Neal Reynolds, University of Maryland School of Medicine
Virginia Rowthorn, University of Maryland Francis King Carey School of Law
Dawn Shojai, University of Maryland School of Pharmacy

Barney Stern, University of Maryland School of Medicine
Earl Stoddard, The University of Maryland Center for Health & Homeland Security
Melissa Tiedeman, University of Maryland School of Pharmacy
Ann WalshState Office of Rural Health, Department of Health and Mental Hygiene
Joy Weber, Rifkin, Livingston, Levitan & Silver, LLC
Rondalyn Whitney, University of the Sciences/Maryland Occupational Therapy Association
Jennifer Witten, American Heart and Stroke Association
Teresa Zent, American Heart Association
Christine Zimmerman, Kaiser Permanente
Marc Zubrow, University of Maryland

Technology Solutions and Standards Advisory Group
David Sharp, Maryland Health Care Commission (Chair)
Raymond Adkins, Peninsula Regional Medical Center
Lee Barrett, Electronic Health Network Accreditation Commission
Tyler Bennett, Alexander & Cleaver
Ed Brill, MedVision, LLC
Bill Byers, Western Maryland Health System
Ernest Carter, Prince George's County Department of Health
Jennifer Chasse, Department of Legislative Services
Ned Cheston, Riverside Health
Aviana Cooper, MD General Assembly/Office of Senator Verna Jones-Rodwell
Philip Cronin, Maryland Psychiatric Society/Harris Jones & Malone, LLC
Joseph Daniels, Consumer
Jim Darchicourt, Maryland Institute for Emergency Medical Services Systems
Charlotte Davis, Rural Maryland Council
Linda Dietsch, Maryland Physicians Care
Jayfus Doswell, Juxtopia, LLC
Peggy Duckworth, Verizon Enterprise Solutions
Seth Eaton, MedPeds, LLC
Robert Enton, Gordon Feinblatt, LLC (United Healthcare)
Albert Ferreira, Holy Cross Health Network
Cynthia Fleig, UnitedHealthcare
John Fleig, UnitedHealthcare
Alexis Slagle Gilroy, Nelson Mullins Riley & Scarborough, LLP
Peter Greene, Johns Hopkins Hospital and School of Medicine
Howard Haft, Shah Associates
Jeanne Hamilton, Maryland Physicians Care
Sheila Higdon, Johns Hopkins
David Horrocks, Chesapeake Regional Information System for our Patients

Anna Jeffers, Maryland Board of Pharmacy
Changrong Ji , CareFirst BlueCross BlueShield
David Jones, Maryland Board of Pharmacy
Simon King, MedVision, LLC
Barbara Klein, University of Maryland
John Kornak, University of Maryland Medical Center
Anne Lara, Union Hospital of Cecil County
Luigi Leblanc, Zane Networks, LLC
Susan Lee, Maryland House of Delegates
Judith Lelchook, National Association of Social Workers - Maryland Chapter
Lisa Lyons, Allegany County Health Department
Steve Mandell, Johns Hopkins Hospital and School of Medicine
Arumani Manisundaram, Adventist HealthCare, Inc.
Mary Mastrandrea, ValueOptions
Paul Messino, Department of Health and Mental Hygiene
Ron Moser, Electronic Health Network Accreditation Commission
Alex Nason, Specialists On Call, Inc.
Diana Nolte, Worcester County Health Department
Christopher Novaco, MedStar Health Information Services
Adelline Ntatin, Department of Health and Mental Hygiene
Robert Perrone, Anne Arundel Health Department
Senator Catherine Pugh, Maryland General Assembly
Ellen Rappaport, Wexford Health
Molly Reyna, Specialists On Call, Inc.
Neal Reynolds, University of Maryland School of Medicine
Deb Rivkin, CareFirst BlueCross BlueShield
Brian Shepter, Harris Jones & Malone
Barney Stern, University of Maryland School of Medicine
Del Tillman, InTouch Health
Anne Timmons, Department of Budget and Management
Arti Varanasi, Advancing Synergy
Ann Walsh, State Office of Rural Health, Department of Health and Mental Hygiene
Joe Warren, Johns Hopkins Hospital and School of Medicine
Adam Weinstein, MHCC/Practicing Nephrologist
Maury Weinstein, System Source
Jennifer Witten, American Heart and Stroke Association
Katie Wunderlich, Maryland Hospital Association
Teresa Zent, American Heart Association

Finance and Business Model Advisory Group

Ben Steffen, Maryland Health Care Commission (Chair)
Margaret Blasi, Department of Health and Mental Hygiene
Jessica Boutin, CareFirst BlueCross BlueShield
David Brennan, MedStar Institute for Innovation
Patrick Carlson, Maryland General Assembly
Jennifer Chasse, Department of Legislative Services
Ned Cheston, Riversidehealth
Matt Emerson, Johns Hopkins Medicine
Stuart Erdman, Johns Hopkins Health System
Cynthia Fleig, UnitedHealthcare
Zereana Jess-Huff, ValueOptions – Maryland
RobertKertis, Calvert Memorial Hospital
Robert Kritzler, Johns Hopkins HealthCare LLC
Susan Lee, Maryland House of Delegates
Christi Megna, Department of Health and Mental Hygiene
Cheryl Nottingham, Atlantic General Hospital
Susan Phelps, Johns Hopkins HealthCare LLC
Senator Catherine Pugh, Maryland General Assembly
Neal Reynolds, University of Maryland School of Medicine
Tricia Roddy, Department of Health and Mental Hygiene
Raquel Samson, Department of Health and Mental Hygiene
Nicole Stallings, Maryland Hospital Association
Barney Stern, University of Maryland School of Medicine
Jennifer Witten, American Heart and Stroke Association
Teresa Zent, Volunteer, American Heart Association

Staff
David Sharp, MHCC
Sarah Orth, MHCC

Meeting Dates
July 24, August 14, August 22, September 11, September 23, October 10, October 24, November 5, and November 18

Appendix B: Healthiest Maryland Participants and Regions[3]

	Company	County	Industry
1	A&G Pharmaceutical Inc.	Howard County	Health Care and Social Assistance
2	ACM Chesapeake, LLC	Talbot County	Information
3	ACT Personnel Service, Inc.	Allegany County	Professional, Scientific, and Technical Services
4	Adventist Healthcare	Montgomery County	Health Care and Social Assistance
5	AES Warrior Run	Allegany County	Utilities
6	Aetna	State-wide	Finance and Insurance
7	Allegeant Accoutable Care Solutions	Baltimore County	Health Care and Social Assistance
8	Alliant Tech Systems	Out-of-State	Manufacturing
9	American Diabetes Association Maryland Office	Baltimore City	Health Care and Social Assistance
10	Anderson, Coe & King, LLP	Baltimore City	Professional, Scientific, and Technical Services
11	Anne Arundel County Government	Anne Arundel County	Public Administration
12	Anne Arundel County Public Schools	Anne Arundel County	Educational Services
13	Anne Arundel Medical Center	Anne Arundel County	Health Care and Social Assistance
14	AQUA Pools & Spas	Talbot County	Other Services (except Public Administration)
15	Aquafit LLC	Kent County	Arts, Entertainment, and Recreation
16	Arc of Washington County Inc.	Washington County	Health Care and Social Assistance
17	Atlantic General Hospital	Worcester County	Health Care and Social Assistance
18	Atlantic/Smith, Cropper & Deeley, LLC	Wicomico County	Finance and Insurance
19	Audacious Inquiry	Howard County	Management of Companies and Enterprises
20	Ayers/Saint/Gross	Baltimore City	Professional, Scientific, and Technical Services
21	Baltimore City Community College	Baltimore City	Educational Services
22	Baltimore County Public Schools	Baltimore County	Educational Services
23	BioMarker Strategies	Baltimore City	Professional, Scientific, and Technical Services

[3] A Healthiest Maryland Businesses participant is a Maryland employer that has signed on to the initiative. Official enrollment entails co23mpleting a commitment letter and/or a brief organizational assessment.

24	BOC International	Baltimore County	Health Care and Social Assistance
25	Bon Secours Baltimore Health System	Baltimore City	Health Care and Social Assistance
25	Brick Bodies / Lynne Brick's	Baltimore County	Arts, Entertainment, and Recreation
27	Business Health Services	Baltimore City	Professional, Scientific, and Technical Services
28	Calvert Memorial Hospital	Calvert County	Health Care and Social Assistance
29	Calvin B. Taylor Banking Company	Worcester County	Finance and Insurance
30	Camp Tockwogh	Kent County	Arts, Entertainment, and Recreation
31	Canam Steel Corporation	Frederick County	Manufacturing
32	Capitol Cadillac	Prince George's County	Retail Trade
33	CareFirst BlueCross BlueShield	Baltimore County	Finance and Insurance
34	Caroline Center	Caroline County	Health Care and Social Assistance
35	Caroline County Chamber of Commerce	Caroline County	
36	Caroline County Health Department	Caroline County	Health Care and Social Assistance
37	Caroline County Public Schools	Caroline County	Educational Services
38	Carroll Chiropractic & Sports Injury Center	Carroll County	Health Care and Social Assistance
39	Carroll Community College	Carroll County	Educational Services
40	Carroll County Health Department	Carroll County	Health Care and Social Assistance
41	Carroll County Public Schools	Carroll County	Educational Services
42	Carroll Hospital Center	Carroll County	Health Care and Social Assistance
43	Carroll Lutheran Village	Carroll County	Health Care and Social Assistance
44	Cecil County Health Department	Cecil County	Health Care and Social Assistance
45	Chesapeake Hearing Centers Inc.	Anne Arundel County	Health Care and Social Assistance
46	Chesapeake Urology Associates	State-wide	Health Care and Social Assistance
47	Chester River Health System	Kent County	Health Care and Social Assistance
48	Choptank Community Health System	Caroline County	Health Care and Social Assistance
49	Choptank Electric Cooperative	Caroline County	Utilities

50	Choptank Transport	Caroline	Transportation and Warehousing
51	Cianbro	Anne Arundel County	Construction
52	City of Bowie	Prince George's County	Public Administration
53	City of College Park	Prince George's County	Public Administration
54	City of Cumberland	Allegany County	Public Administration
55	City of Frederick	Frederick County	Public Administration
56	City of Gaithersburg	Montgomery County	Public Administration
57	City of Greenbelt	Prince George's County	Arts, Entertainment, and Recreation
58	City of Rockville	Montgomery County	Public Administration
59	City of Salisbury	Wicomico County	Public Administration
60	City of Taneytown	Carroll County	Public Administration
61	Clear Channel Outdoor	Wicomico County	Other Services (except Public Administration)
62	College of Notre Dame	Baltimore City	Educational Services
63	Commercial Insurance Managers INC	Howard County	Health Care and Social Assistance
64	Community Bank of Tri-County	Charles County	Finance and Insurance
65	Community College of Baltimore County (Dundalk)	Baltimore County	Educational Services
66	Community Counseling & Mentoring Services, Inc.	Prince George's County	Health Care and Social Assistance
67	Corporate Network Services	Montgomery County	Professional, Scientific, and Technical Services
68	Corporate Office Properties Trust	Howard County	Real Estate and Rental and Leasing
69	Crossroads Community, Inc	Queen Anne's County	Health Care and Social Assistance
70	Curves	Kent County	Health Care and Social Assistance
71	David A. Bramble, Inc.	Kent County	Construction
72	David Edward	Baltimore County	Manufacturing
73	Deers Head	Wicomico County	Health Care and Social Assistance
74	Deutsch & Associates, LLC	Montgomery County	Finance and Insurance
75	Dixon, Valve, and Coupling	Kent County	Manufacturing
76	Doctors Community Hospital	Prince George's County	Health Care and Social Assistance
77	Dorchester County Family YMCA	Dorchester County	Health Care and Social Assistance

78	Dorchester County Health Department	Dorchestor County	Health Care and Social Assistance
79	Dynaxis	Montgomery County	Professional, Scientific and Technical Services
80	Eastern Shore Area Health Education Center	Dorchester County	Educational Services
81	Easton Utilities	Talbot County	Utilities
82	Educators Benefit Services	Anne Arundel	Finance and Insurance
83	Erickson Retirement Communities	State-wide	Real Estate and Rental and Leasing
84	Euler Hermes	Baltimore County	Finance and Insurance
85	Every Body Yoga and Wellness	Queen Anne's County	Other Services (except Public Administration)
86	Forest City - NEBP	Baltimore City	Construction
87	Frederick County Citizens Division	Frederick County	Public Administration
88	Frederick Memorial Hospital	Frederick County	Health Care and Social Assistance
89	Friends Aware	Allegany County	Other Services (except Public Administration)
90	G.1440	Baltimore City and Howard County	Professional, Scientific, and Technical Services
91	Garrett County Memorial Hospital	Garrett County	Health Care and Social Assistance
92	GE Aviation; Middle River Aircraft Systems	Baltimore County	Manufacturing
93	George, Miles & Buhr	Wicomico County	Professional, Scientific, and Technical Services
94	Gillespie & Son Inc	Kent County	Manufacturing
95	Gliknik Inc.	Baltimore City	Professional, Scientific, and Technical Services
96	Goodwill Industries of the Chesapeake, Inc.	Baltimore City	Other Services (except Public Administration)
97	Grant Thornton	Baltimore City	Finance and Insurance
98	Greater Maryland Medical Center	Baltimore City	Health Care and Social Assistance
99	Harford Community College	Harford County	Educational Services
100	Harford-Belair Cardiometabolic Health Congress (CMHC)	Baltimore City	Health Care and Social Assistance
101	Health Care for the Homeless	Baltimore City	Health Care and Social Assistance
102	Healthy Howard, Inc	Howard County	Health Care and Social Assistance
103	Healthy Snacks 4 You, Inc.	Cecil County	Health Care and Social Assistance

104	Heron Point of Chestertown	Kent County	Health Care and Social Assistance
105	Hord Coplan Macht, Inc.	Baltimore City	Other Services (except Public Administration)
106	Housing Opportunities Commission of Montgomery County	Montgomery County	Real Estate and Rental and Leasing
107	Howard County Health Department	Howard County	Public Administration
108	Hub Labels Inc.	Washington County	Manufacturing
109	Human Services Programs of Carroll County, Inc.	Carroll County	Health Care and Social Assistance
110	iBiquity	Howard County	Other Services (except Public Administration)
111	Ikea	Cecil County	Transportation and Warehousing
112	Injured Workers Insurance Fund	Baltimore County	Finance and Insurance
113	Innovative Benefit Solutions LLC	Worcester County	Finance and Insurance
114	Interstate Container	Dorchestor County	Manufacturing
115	JBS International	Montgomery County	Professional, Scientific and Technical Services
116	JBS International	Montgomery County	Health Care and Social Assistance
117	Jenkins Block and Associates, PC	Baltimore County	Professional, Scientific, and Technical Services
118	Jerry's Chevrolet Company	Baltimore County	Construction
119	Johns Hopkins Health System / Johns Hopkins Hospital	Baltimore City	Health Care and Social Assistance
120	Jolles Insurance	Howard County	Finance and Insurance
121	Jon S. Frank and Associates	Calvert County	Finance and Insurance
122	Joyous Living	Calvert County	Health Care and Social Assistance
123	Jubiliee Association	Montgomery County	Health Care and Social Assistance
124	K&L Microwave, Inc	Wicomico County	Manufacturing
125	Kaiser Permanente	State-wide	Finance and Insurance
126	Kelly & Associates Insurance Group	Baltimore County	Finance and Insurance
127	Kent Athletic and Wellness Center	Kent County	Arts, Entertainment, and Recreation
128	Kent Center Inc	Kent County	Health Care and Social Assistance
129	Kent County Chamber of Commerce	Kent County	Other Services (except Public Administration)
130	Kent County Department of Social Services	Kent County	Health Care and Social Assistance

131	Kent County Health Department	Kent County	Health Care and Social Assistance
132	Kent County Public Schools	Kent County	Educational Services
133	Kent Youth Inc.	Kent County	Other Services (except Public Administration)
134	Konsyl Pharmaceuticals, Inc.	Talbot County	Manufacturing
135	LaMotte Company	Kent County	Manufacturing
136	Liesure Fitness	Montgomery County	Retail Trade
137	Life Fitness Management	Allegany County	Other Services (except Public Administration)
138	LifeBridge Health	Baltimore City and Baltimore County	Health Care and Social Assistance
139	Lifeguard Wellness	Howard County	Health Care and Social Assistance
140	Longevity Studios	Charles County	Professional, Scientific and Technical Services
141	Luke Paper Company	Allegany County	Manufacturing
142	Manual Physical Therapy and Sports Medicine	Baltimore County	Health Care and Social Assistance
143	Marriott International	Montgomery County	Accomodation and Food Services
144	Maryland Citizens Health Initiative Education Fund Inc.	Baltimore City	Other Services (except Public Administration)
145	Maryland Healthy Weighs, LLC	Dorchester County	Health Care and Social Assistance
146	Maryland Hospital Association	Howard County	Health Care and Social Assistance
147	McCormick & Company, Inc.	Baltimore County	Manufacturing
148	Medifast, Inc	Baltimore County	Other Services (except Public Administration)
149	MedStar Health, Inc.	Howard County	Health Care and Social Assistance
150	MedStar St. Mary's Hospital	St. Mary's County	Health Care and Social Assistance
151	Mel's Business Systems, Inc	Allegany County	Retail Trade
152	Meritus Health Inc.	Washington County	Health Care and Social Assistance
153	MidAtlantic Business Group on Health	Prince George's County	Management of Companies and Enterprises
154	Mid-Delmarva Family YMCA	Wicomico County	Arts, Entertainment, and Recreation
155	Miltec Corporation	Queen Anne's County	Manufacturing
156	Montgomery College	Montgomery County	Educational Services

157	Montgomery County Public Schools	Montgomery County	Educational Services
158	Mt Washington Pediatric Hospital	Baltimore City	Health Care and Social Assistance
159	Municipal Employees Credit Union of Baltimore (MECU)	Baltimore City	Finance and Insurance
160	My Transportation	Prince George's County	Transportation and Warehousing
161	National Aquarium	Baltimore City	Arts, Entertainment, and Recreation
162	New Windsor State Bank	Carroll County	Finance and Insurance
163	Nexercise	Montgomery County	Professional, Scientific, and Technical Services
164	Northrop Grumman Corporation	Anne Arundel County	Professional, Scientific, and Technical Services
165	Novartis Pharmaceuticals	State-wide	Health Care and Social Assistance
166	Peninsula Cardiology Associates, P.A	Wicomico County	Health Care and Social Assistance
167	Peninsula Regional Medical Center	Wicomico County	Health Care and Social Assistance
168	Perdue Farms	Anne Arundel and Wicomico County	Poultry Processing
169	Pfizer	Prince George's County	Finance and Insurance
170	Pfizer Inc.	Baltimore City	Health Care and Social Assistance
171	Playworks	Baltimore City	Educational Services
172	PNC Bank	State-wide	Finance and Insurance
173	Praxis Engineering	Anne Arundel County	Professional, Scientific, and Technical Services
174	Preston Automotive Group	Caroline	Retail Trade
175	Price Modern LLC	Baltimore City	Retail Trade
176	Prince George's County Government		Other Services
177	QIAGEN	Montgomery County	Manufacturing
178	Queen Anne's Co Dept of Health	Queen Anne's County	Health Care and Social Assistance
179	RCM&D	Baltimore County	Finance and Insurance
180	Reliable Contracting Co., Inc	Anne Arundel County	Construction
181	Richard J Princinsky and Associates	Baltimore County	Finance and Insurance
182	RSM McGladrey	Baltimore County	Professional, Scientific, and Technical Services
183	Rummel, Klepper & Kahl LLP (RK&K)	Baltimore City	Professional, Scientific, and Technical Services

184	Saint Agnes Hospital	Baltimore City	Health Care and Social Assistance
185	Salisbury University	Wicomico County	Educational Services
186	Salvere Health & Fitness	Howard County	Other Services
187	Scott Key Center, Inc.		Other Services (except Public Administration)
188	Shore Bancshares, Inc.	Talbot County	Finance and Insurance
189	Shore Health System	Dorchestor County	Health Care and Social Assistance
190	SMECO	Charles County	Utilities
191	Spirit Creative Services, Inc.	Anne Arundel County	Arts, Entertainment, and Recreation
192	Sport and Spine Rehab	Prince George's County	Health Care and Social Assistance
193	Sports Automotive	State-wide	Other Services (except Public Administration)
194	St. Mary's County Government	St. Mary's County	Public Administration
195	St. Mary's County Health Department	St. Mary's County	Health Care and Social Assistance
196	St. Mary's Nursing & Rehabilitation Center	St. Mary's County	Health Care and Social Assistance
197	State of Maryland	State-wide	Public Administration
198	Stevenon University	Baltimore County	Educational Services
199	Talbot County Department of Social Services	Talbot County	Health Care and Social Assistance
200	Talbot County Health Department	Talbot County	Health Care and Social Assistance
201	TBC Inc.	Baltimore City	Other Services (except Public Administration)
202	The Aspen Group, Inc.	State-wide	Professional, Scientific, and Technical Services
203	The Bank of Delmarva	Wicomico County	Finance and Insurance
204	The Henry M. Jackson Foundation for the Advancement of Military Medicine	Montgomery County	Other Services (except Public Administration)
205	The Horizon Foundation	Howard County	Other Services (except Public Administration)
206	The PharmaCareNetwork	Allegany County	Health Care and Social Assistance
207	The Tower Companies	Montgomery County	Real Estate and Rental and Leasing
208	The Wills Group	Charles County	Wholesale Trade
209	Thrasher Engineering	Garrett County	Professional, Scientific, and Technical Services

210	Total Biz Fulfillment, Inc	Garrett County	Transportation and Warehousing
211	Town of Bladensburg	Prince George's County	Public Administration
212	Town of Chestertown	Kent County	Public Administration
213	Town of Perryville	Cecil County	Public Administration
214	Transamerica Life Insurance Company	Baltimore City	Finance and Insurance
215	Ulman Cancer Fund for Young Adults	Howard County	Other Services (except Public Administration)
216	Union Hospital of Cecil County	Cecil County	Health Care and Social Assistance
217	United Healthcare	State-wide	Finance and Insurance
218	University of Maryland Baltimore	Baltimore City	Educational Services
219	University of Maryland School of Medicine	Baltimore City	Health Care and Social Assistance
220	University Physcians, Inc	Baltimore City	Health Care and Social Assistance
221	Upper Chesapeake Health	Harford County	Health Care and Social Assistance
222	Verizon	State-wide	Other Services (except Public Administration)
223	Volvo Group Trucks	Washington County	Manufacturing
224	Washington College	Kent County	Educational Services
225	Washington County Public Schools	Washington County	Public Administration
225	Waterman's Crab House	Kent County	Other Services (except Public Administration)
227	WellAdvantage	Carroll County	Health Care and Social Assistance
228	West Cecil Health Center	Cecil County	Health Care and Social Assistance
229	Western Maryland Area Health Education Center (AHEC)	Allegany County	Health Care and Social Assistance
230	Western Maryland Health System	Allegany County	Health Care and Social Assistance
231	Wicomico Co. Board of Education	Wicomico County	Educational Services
232	Wicomico Co. Health Dept.	Wicomico County	Health Care and Social Assistance
233	William Hill Manor	Talbot County	Health Care and Social Assistance
234	Wisp Resort	Garrett County	Arts, Entertainment, and Recreation
235	WMDT	Wicomico County	Information
236	Work Smart Ergonomics	Baltimore City	Professional, Scientific, and

			Technical Services
237	Y of Central Maryland	Baltimore City	Health Care and Social Assistance
238	YMCA of the Chesapeake	Caroline	Health Care and Social Assistance

Healthiest Maryland Businesses- Supporting Organizations[4]

	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
14	Maryland Cancer Collaborative	Health Care and Social Assistance
15	Maryland Department of Aging	Public Administration
16	Maryland Health Care for All! Coalition	Public Administration

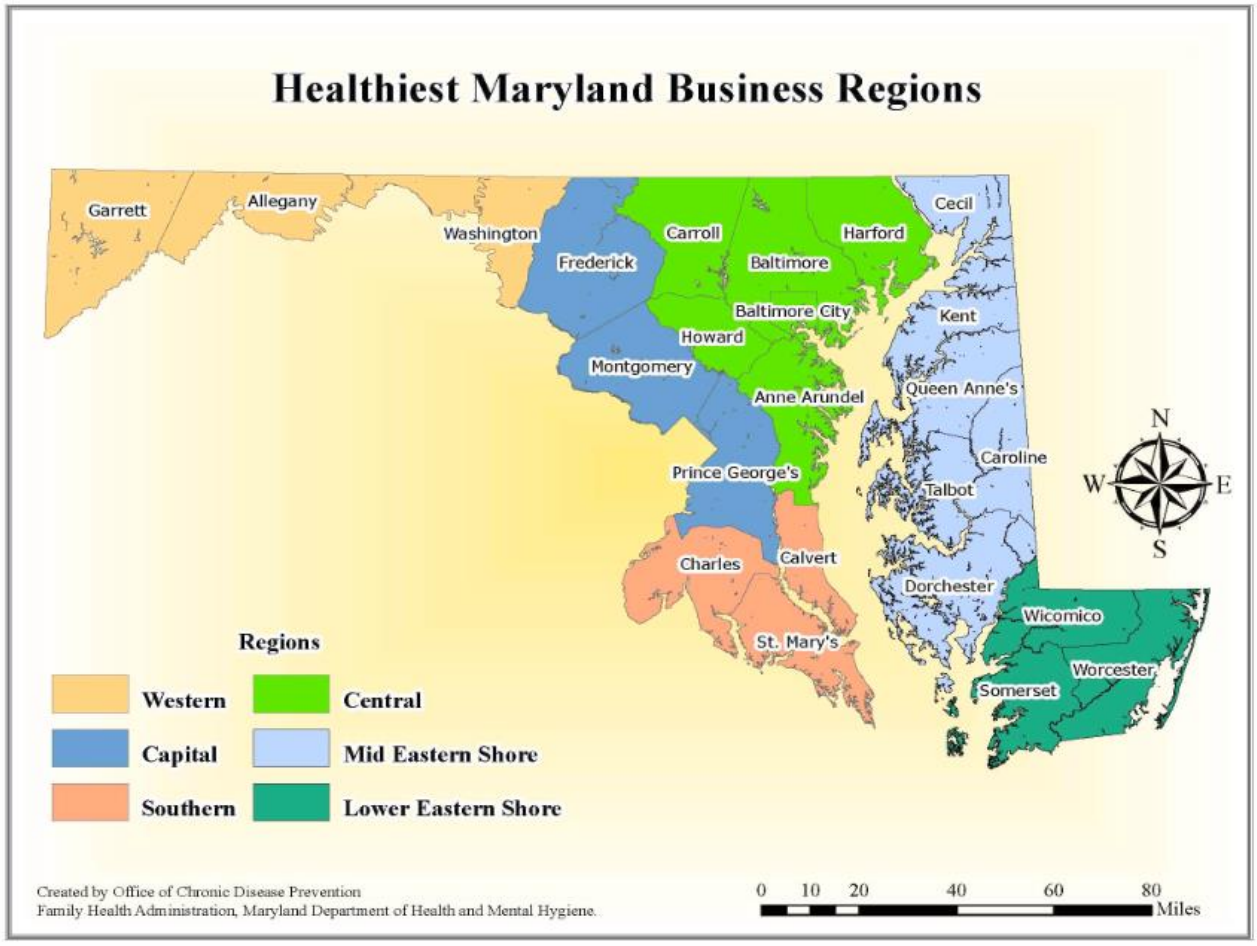
[4] A Healthiest Maryland Businesses Supporting Organization is a worksite wellness partner with subject matter expertise that provides resources to Maryland employers.

17	Maryland Hospital Association	Health Care and Social Assistance
18	Maryland Recreation and Parks Association	Health Care and Social Assistance
19	Maryland P3 Program	Health Care and Social Assistance
20	MidAtlantic Business Group on Health	Other Services (except Public Administration)
21	National Committee for Quality Assurance	Health Care and Social Assistance
22	Partnership for Prevention	Health Care and Social Assistance
23	Partnership for a Healthier Carroll County	Health Care and Social Assistance
24	Small Business Majority	
25	Western Maryland Health System	Health Care and Social Assistance
26	Wicomico County Health Department	Public Administration
27	Worcester County Health Department	Public Administration

Healthiest Maryland Businesses- Ambassadors[5]

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

[5] 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.


Healthiest Maryland Business Regions
Garrett
Allegany
Washington
Frederick
Carroll
Harford
Cecil
Baltimore
Baltimore City
Kent
Howard
Montgomery
Queen Anne's
Anne Arundel
Caroline
Prince George's
Talbot
Charles
Calvert
Dorchester
Wicomico
St. Mary's
Worcester
Somerset
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W
E
S
Regions
Western
Central
Capital
Mid Eastern Shore
Southern
Lower Eastern Shore
Created by Office of Chronic Disease Prevention
Family Health Administration, Maryland Department of Health and Mental Hygiene.
0 10 20 40 60 80
Miles

Appendix C: Healthiest Maryland Businesses Success Stories

Easton Utilities

A Healthiest Maryland Businesses Success Story

Results-Driven Wellness Works

Founded in 194, Easton Utilities (EU) is the first municipality in Maryland to own its utilities. Currently, EU provides service for electric, natural gas, water, wastewater, cable TV, internet, digital voice and IT professional services.

Like most public power companies, EU has an aging workforce, with an average age of 43. They realized that a wellness program would be needed to keep their employees healthy and productive.

Beginnings of Wellness

EU's wellness program began in an unstructured way. They began with health education events, offering "lunch and learns," using local resources to talk about health topics. One of the first programs was Weight Watchers at Work, when employees collectively lost over 200 pounds. EU paid for half of the program cost, and if employees reached their goal, EU would reimburse for the remainder. In 2008, with the help of their insurance broker's wellness consultant and their insurance carrier, they began developing long-term strategic goals and actions for a more results-oriented program.

Foundational Elements

They started by aligning key elements: gaining senior level support, forming a wellness committee, having a budget in place, designing a strategic plan and developing an evaluation tool. From the outset, EU president Hugh Grunden's goal was "to carry the the initiative from top management throughout the company, truly cultivating a culture of wellness."

Hugh's personal journey towards wellness is a familiar one for many.

Like most CEOs, his job is very demanding. He was more concerned with work than himself. After having a heart attack in 2000, he returned to work energized and committed to caring for himself and for the health of his employees. He not only encourages healthy lifestyle choices in the workplace—he is a model for making them. He eats healthfully, has lost weight and is a committed gym member. He participated in and was a motivational leader of

the 5K family run in Spring 2012.

The Program

A representative wellness committee was formed, which meets quarterly. They provide input for the yearly plan design, as well as implement and communicate about upcoming events. The first official wellness activity was to write a vision statement for wellness and hold a logo contest. The logo is a visual way to cement the idea that wellness is part of the company culture. As the wellness program continues to evolve, the committee is developing more programs and activities for employees.

EU has a wellness budget, and their insurance carrier pledges money to be used for wellness initiatives. The pledged money is used to cover expenses for onsite biometric screening and to fund incentives for employees to complete an online health risk assessment. EU has been fortunate to find low cost speakers using the wellness consultant. Local agencies, EAP, and speakers' bureau from hospitals. EU has developed a strategic long term plan based on a yearly wellness scorecard, a sample is attached. While the types of challenges vary each year, at its core are biometric screenings, health risk assessments, annual physicals and participation in wellness activities. The scorecard offers options to employees. When an employee earns 100 points, he or she has completed their annual wellness goal.

EU has made environmental changes as well. The main office building is now an inviting place for employees to practice healthy behaviors. An empty space next to the main break room was turned into a fitness room. Here, weekly fitness classes are taught by a certified trainer. Other classes offered periodically include yoga, P90 and Insanity. To encourage healthy snacking, fresh fruit is available for .25 in every break room.

Positive Results

For the past three years, EU has tracked participation, health risks and employee satisfaction. Since 2009, there has been an average of 92 percent participation in the wellness scorecard program. Regarding risks, the goal of the program is to move individuals from high to medium or low risk, and keep those who are in the low risk category. Over three years, the high risk group has gone from 14% to 10%; the medium risk group from 36% to 33%, and the low risk from 50% to 57%. Each year, employees complete a wellness evaluation. This past year, over 75% of employees completing the survey said that their health and wellness knowledge has "increased due to participation in the wellness initiative. Sixty-eight percent have "made improvements in health and lifestyle as a result of the wellness initiative."

Significantly, EU's insurance carrier will be refunding an estimated $100,000 over the coming year. The current loss ratio is 72%, which is the lowest in five years. In addition, the turnover rate remains steady at 3.5% and there have been no short or long term disability claims since the wellness plan's inception.

McCormick

A Healthiest Maryland Businesses Success Story

Streamlining Makes Benefits Work

McCormick, established in 1889 and based in Hunt Valley and Sparks, Maryland, is commonly known as a company that sells jars of spices and seasonings. The company is actually a global manufacturer, distributor and marketer of flavoring products to both consumers and the food industry.

Globally, McCormick employs nearly 10,000 people, with 3,400 of them in the United States. Sixty-eight percent of McCormick's U.S. workforce is located in Maryland, while the remaining 30 percent is in five other states: Texas, Georgia, California, Indiana and Louisiana. The average employee is 45 years of age and has been with the company for 12.7 years.

In 2008, the company had a robust, but inconsistent focus when it came to health benefits, according to James Downing, Director of Global Benefits. At that time, the company had four health plan carriers (four HMOs, one PPO), various wellness programs, and a divided internal administration of health and wellness plans, managed by both the corporate human relations department and the company medical department.

This structure created a number of challenges for developing a systems approach to health benefits. This included design inconsistency due to having several different plans and carriers, an inability to provide focused communications about wellness benefits, and poorly defined roles and responsibilities for key staff.

In addition, the company faced an increasing burden on its system due to the aging workforce, rising healthcare costs, regulatory changes, decentralization of providers and increased utilization of healthcare services.

In 2010, McCormick decided to confront its challenges head on and redesign its benefits program in order to strengthen and enhance their employer-paid health benefits.

They planned to achieve this goal by:

- Simplifying administration
- Creating renewed interest among employees through communications
- Better aligning with employee needs and preferences
- Taking a holistic and integrated approach to delivery of services
- Centralizing medical programs through one vendor

The first step in this process was to issue a request for proposals (RFP) for all of the company's health and wellness program needs, including medical, dental, life, disability,

and vision. In order to make the system uniform and benefits easier to manage, the company created a branded benefits program and website, McCormickandme.com. An employee newsletter was developed so that timely benefits information could be communicated to employees. To simplify administration and improve accountability, management of the medical department was shifted to the corporate benefits group.

By July, 2011, the company had successfully achieved many of their objectives. The company now has one main medical plan provider, a voluntary vision program, and a new life insurance carrier. In 2012, they added consumer driven health plans with a health spending account.

In addition, under the management of the corporate benefits group, the company medical department's focus has shifted to being a true onsite medical facility. In addition to providing wellness programs for Hunt Valley based employees, wellness programs now also focus on employees at other locations. In the fall of 2011, the company moved the medical department to a more central location to provide better access for all employees to medical care and improved wellness facilities.

McCormick was successful in making dramatic changes to its benefits programs in a very compressed timeframe: less than a year. This was necessary due to the need to meet regulatory requirements, improve employee satisfaction, attract and retain employees, and to establish an employee comfort level with the new providers and processes.

These types of radical changes are not easy to achieve in any corporation and McCormick was especially challenged because of employee culture at the time. There were mixed emotions about change, and employees had to accept and process many changes in a short period of time. Ultimately, the employees' ability to adapt and change led to a greater satisfaction with the entire health benefits program.

Appendix D: Cultural Competency Workgroup Report

(Report begins on next page)

Maryland Health Quality and Cost Council

The Honorable Anthony G. Brown
Lieutenant Governor, State of Maryland
Council Chair

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

Cultural Competency Workgroup Report

Maryland Cultural, Linguistic and Health Literacy Competency Strategies: A Policy Framework for 2013-2020

Lisa A. Cooper, MD, MPH, Director, Johns Hopkins Center to Eliminate Cardiovascular Health Disparities, James F. Fries Professor of Medicine, Johns Hopkins University School of Medicine, Co-Chair

Marcos Pesquera, RPh, MPH, Executive Director,
Adventist Healthcare Center on Health Disparities, Co-Chair

December 6, 2013

Maryland Cultural Competency Strategies and Policy Framework 2013-2020

Contents

Executive Summary

Maryland is a State on the move in 2013. Building on hospital rate setting in the 1970s and Medicaid expansion during the intervening years, the State has established the Maryland Health Quality and Cost Council (MHQCC), the Maryland Health Care Reform Coordinating Council (MHCRCC), and passed several pieces of legislation to reform and modernize the health system. Maryland's health vision for the next decade includes a population health approach; improved patient outcomes and experience; reformed payment and incentives that lead to cost-effective operations; reaching all populations with services they need and can use; and accountability to tax payers and citizens.

The State's population of about 6 million residents includes over 2.6 million minorities and 800,000 immigrants from many counties. This population mix of 45.3% minorities in 2010, and a projected 51% in 2020, calls for special attention to enable health care, behavioral health and social services to be most cost-effective for a diverse population. Recognizing the importance of positive and effective patient-provider encounters in health interactions, Maryland along with other states have passed legislation and enacted requirements to ensure that the health care workforce is culturally, linguistically and health literacy competent and prepared to be effective.

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the Maryland Health Quality and Cost Council (MHQCC) to form the Cultural Competency Workgroup to explore and make recommendations on how the State could increase the cultural, linguistic, and health literacy competency of health providers and health care delivery organizations throughout Maryland. Forty-seven persons were appointed to serve on the Workgroup. There were three legislative charges: 1) develop recommendations for cultural competency standards and tiered reimbursement for medical and behavioral service settings; 2) recommend standards for multicultural health in Patient Centered Medical Homes (and other health care settings); and 3) propose standards for continuing education in cultural competency for health care providers.

The Workgroup process involved three meetings of the full membership. At the November 2012 meeting, the three charges from the MHQCC were defined. Members divided themselves into three subcommittees, each to address a respective charge. Ongoing work took place at the subcommittee level. At the January 2013 meeting, a presentation on cultural competency was conducted by Ms. Darci Graves from SRA International. At the May 2013 meeting, the Subcommittees discussed their work progress and their expected deliverables. Throughout this period, Subcommittee Co-chairs coordinated ongoing work via teleconferences, electronic communication and in-person meetings and produced Subcommittee final reports by July 2013. Workgroup Co-Chairs Dr. Lisa Cooper and Mr. Marcos Pesquera provided updated reports to the MHQCC in December 2012 and March and September of 2013.

A team of 10 volunteers in the Staff Support Group representing academic institutions and diverse health equity experts, worked with State staff and Workgroup members to research and develop recommendations for the charges. Oversight was provided by the Office of Minority Health and Health Disparities in partnership with the Maryland Health Care

Commission. Together, these staff and volunteers conducted widespread research of cultural, linguistic and health literacy competency and related practices and publications throughout the nation. As a result, a total of 19 dedicated professional staff and 44 health equity experts spent time on this project from the fall of 2012 through October 2013. This final report is a composite of their research, experience and review of a wide array of information. A noteworthy observation is that around the nation, cultural, linguistic and health literacy competency is developing into a central measure for identifying the commitment of organizations and initiatives to the achievement of quality health equity in service delivery as systems seek reform and cost-effectiveness.

The findings and recommendations are summarized below by each of the three legislative charges to the workgroup.

Charge 1: *"Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;"*

- Cultural and Linguistic Competency assessment and reporting were found to be both feasible and desirable.
- Standards for the cultural and linguistic competency performance assessment of medical and behavioral health care providers were found to be currently applied in some settings.
- Linking tiered reimbursement rates by payors to medical and behavioral health care providers' cultural and linguistic competency performance assessment results was found to be desirable, but the feasibility will require a more broad experience with assessment and reporting.
- At least 14 states and the District of Columba reimburse language services on a per service basis in their Medicaid programs, either for their Fee –For-Service enrollees or for all enrollees.

Recommendations:

- Integrate the *Maryland RELICC Assessment* quality measurement tool for addressing disparities to the metrics reported in the Maryland *Health Benefit Plan Quality and Performance Report* and in the metrics used to assess the quality of the qualified health plans participating in the State's Health Benefit Exchange, the *Maryland Health Connection.*
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in plan assessment for the Maryland *Health Benefit Plan Quality and Performance Report*. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in assessment of the quality of the State Medicaid MCOs.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in the State's program for assessing hospital quality.
- Ensure that third party payors reimburse healthcare organizations and private physician practices for provision of appropriate language services, including qualified bilingual staff and contractual foreign language and sign language interpreters per encounter, rather than as a bundled payment.

- Assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the State is sufficient to begin to link some portion of reimbursement to performance in those competencies.

Charge 2: *"Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home (PCMH) program and other health care settings."*

- Incorporation of cultural and linguistic competency standards into PCMH assessment programs is feasible: NCQA PCMH recognition standards already incorporate cultural and linguistic competency elements, and several states require this recognition in their PCMH programs.

Recommendations:

- Maryland's PCMH programs should require or incentivize participating practices to meet the cultural competency standards contained in national PCMH recognition products.
- Maryland's PCMH programs should examine the feasibility of using the AHRQ's CAHPS Cultural Competence Item Set for provider-level and practice-level assessment of cultural and linguistic competency. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Maryland's PCMH programs should require or incentivize participating practices to meet the NCQA Multicultural Health Care Standards or a similar standard.
- Maryland's PCMH programs should assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the programs is sufficient to begin to link some portion of reimbursement to performance in those competencies.

Charge 3: *"Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency/health literacy training.*"

- Some states have already developed cultural and linguistic competency continuing education requirements for health professional re-licensure. Maryland should begin to require cultural, linguistic and health literacy competency training for health professional initial licensure and re-licensure.

Recommendations:

- Maryland's health profession boards should require that 5% to 10% of the total continuing education requirement for re-licensure be credits in cultural, linguistic, and health literacy competency.
- Maryland's academic medical centers should identify and/or develop appropriate cultural, linguistic and health literacy competency continuing education materials (both classroom curriculum and individual on-line modules) and make them available to Maryland providers.

- Adopt multicultural health care continuing education (CE) requirements that address the following key components:
    - Amount and frequency of training;
    - Approval process for continuing education credits/units;
    - Curricular structure/Navigation;
    - Compliance monitoring.
- Adopt and promote continuing education curricula that address a standard set of suitable learning objectives adapted from "The Cultural Competency and Health Literacy Primer" (2013). The learning objectives should address health care professionals' knowledge and skills related to cultural diversity, health literacy, cross-cultural communication, proper use of interpreters, bias/stereotyping, social determinants of health, including access to and quality of care, and the impact of these factors on health outcomes and health disparities.
- Adopt and promote continuing education curricula that incorporate a focus on inter-professional education (IPE). An IPE approach enables members of different health profession disciplines to collaborate (and to learn from and with each other) in a teamwork-oriented environment, with the goal of providing the highest quality of care for patients and clients.

The Cultural Competency Workgroup co-chairs, members and staff appreciate the opportunity to investigate this important component of Maryland's initiative to improve health and reduce racial and ethnic disparities among its population. The search was enlightening and elucidating in the discovery of widespread work in cultural, linguistic and health literacy competency at many different levels and sectors of the nation's health and health care delivery system.

I. HEALTH EQUITY AND CULTURAL COMPETENCY IN MARYLAND

A. Challenges and Opportunities for Health Equity in Maryland

The State of Maryland is actively engaged in modernizing its public health and health care delivery systems, linking them both and reforming each to arrive at a new structure with dynamic interaction. The projected results include improved health outcomes and reformed payment and incentive systems that lead to cost- effective operations. Maryland's population of about 6 million residents includes over 2.6 million minorities and almost 800,000 immigrants from many countries. Some of the leading countries of origin for Maryland's minority residents are Nigeria, Ethiopia, Kenya, Jamaica, Haiti, Trinidad & Tobago, El Salvador, Mexico, Dominican Republic, Cuba, India, China and Korea. Among Native Americans in Maryland, prominent tribes in the state include the Cherokee, the Lumbee, and the Piscataway.

This population mix of 45.3% minorities in 2010, and an estimated 51% by 2020, calls for special attention to enable health care, behavioral health and social services to be most cost-effective for a diverse population. In the health care system, citizens are vulnerable due to health illiteracy and the impact of poor health when communicating with health professionals and other staff. Recognizing the importance of communication in health interactions, the Federal government and many states have passed legislation and enacted numerous requirements to ensure that the health care workforce is culturally, linguistically and health literacy competent and prepared to be effective.

While Maryland's diversity (U.S. minorities and immigrants) is increasing, the State's health care delivery and public health workforce is not sufficiently representative of the growing diverse population. For example, African Americans, Hispanics, and Native Americans are underrepresented in the graduates of some of Maryland's health profession schools:

	Black or African American	**Hispanic**	**American Indian or Alaska Native**	**These groups combined**
Maryland Population	**29%**	**8%**	**<1%**	**38%**
Dental School Grads	8%	3%	0%	11%
Medical School Grads	7%	4%	1%	12%
Nursing School (BSN)	29%	3%	<1%	32%
Nursing School (ADN	19%	3%	<1%	22%
Pharmacy School Grads	9%	2%	0%	11%

Source: Office of Minority Health and Health Disparities. Diversity in the Health Professions Fact Sheet. Maryland Department of Health and Mental Hygiene. Baltimore, MD. August 2013.

In addition, there is national-level anecdotal evidence of the under-representation of several Asian/Pacific Islander sub-populations among health profession graduates, although current data collection surveys are not capturing this sub-population data.

B. Current Cultural Competency Initiatives in Maryland

The Department of Health and Mental Hygiene has launched a number of new initiatives over the past two years to implement Maryland's Health Reform program. Among them are the Local State Health Improvement Plans that identify race and ethnic measures for program focus; the Community Integrated Medical Home Project that stimulates innovative service delivery models; the CDC Community Transformation projects that support Statewide and local efforts to reduce chronic disease; the HHS Million Hearts Initiative that strengthens healthy hearts programs; the Maryland Health Enterprise Zones that designated and funded five small geographic areas to saturate resources using diverse community-based partnerships; and the State Health Insurance Marketplace that began enrolling uninsured citizens on October 1, 2013.

Other initiatives underway in the State include the Maryland Health Care Reform Coordinating Council that guides and connects the various ACA efforts; the Maryland Health Quality and Cost Council that promulgates initiatives that focus on increasing quality and safety in health care delivery; the General Assembly's Health and Government Operations subcommittee on Minority Health Disparities that monitors health equity efforts in the State; and health disparities centers at the major health professional institutions.

C. New Strategy for Cultural Competency in Maryland

Looking ahead to 2020 and beyond, Maryland's elected officials, administration, and health system leadership have amplified efforts to accelerate reform of the State's health system.

<u>Health Care Reform Coordinating Council 2011 Initiatives being implemented:</u>

- Diversify Maryland's health care workforce; enhance its cultural and linguistic competence
- Promote and support education and training to expand the State's workforce pipeline
- Explore improvements in policies for licensing health professionals
- Promote cultural, linguistic and health literacy competency assessment and training
- Institute payment reform to incentivize quality improvements and cost savings
- Reduce/eliminate health disparities through financial performance-based incentives.

<u>Maryland pursuit of the Triple Aim in 2014 to address health reform:</u>

- Improve patient satisfaction (cultural, linguistic, health literacy competency is essential)
- Improve health of populations
- Reduce per capita health care costs

<u>Patient Centered Medical Home (PCMH) implementation in 2013:</u>

- Place the patient in the center of the medical intervention and practice
- Empower patients to serve as a team member in their medical management
- Establish organizational and provider cultural and linguistic competency
- Establish health literacy competency
- Use the CAHPS *Cultural Competence Item Set* as part of its program evaluation.

Maryland Health Improvement and Disparities Reduction Act of 2012:

The purpose of the Health Disparities Act of 2012 is to reduce health disparities, improve health outcomes and reduce health costs and hospital admissions and re-admissions. The following provisions are being implemented in the State to achieve these ends:

- Establish Health Enterprise Zones (HEZ)s to target resources to small areas of need
- Require standard measures of race and ethnicity in annual MHCC quality reports
- Require non-profit hospitals to report their efforts to reduce health disparities
- Require health profession educational institutions to report efforts to reduce disparities
- Recommend standards for evaluating the impact of PCMH on health disparities
- Develop standards/criteria for cultural competency in medical and behavioral health.

Maryland Health Care Commission, RELICC Assessment

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the Maryland Health Care Commission (MHCC) to incorporate standard measures regarding race and ethnicity in annual MHCC quality reports. In response to this legislative charge, MHCC began implementing a Maryland specific health benefit plan quality reporting tool in 2013. This tool is the Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC)* Assessment.

- The tool has been successfully pilot tested.
- Maryland commercial carriers operating inside and outside the Exchange are committed to the use of the RELICC tool for reporting.

Maryland Health Quality and Cost Council (MHQCC), 2012 Cultural Competency Workgroup:

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the MHQCC to establish a Cultural Competency Workgroup that would consider policies and strategies to increase cultural, linguistic and health literacy competency among the state's health care providers and organizations. A report with recommendations was mandated, due December 2013. The charges for the Workgroup were:

- Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates;
- Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and
- Recommend criteria for health care providers in Maryland to receive continuing education in multicultural health care, including cultural competency and health literacy training.

II. WORKGROUP METHODOLOGY

There were three in-person meetings of the full Workgroup:

- November 29, 2012: During the inaugural meeting, three separate charges were defined for the workgroup. Workgroup members-at-large were then divided into three Subcommittees established to address one of the three identified charges.
- January 23, 2013: At the second meeting, a presentation on cultural competency was conducted by Ms. Darci Graves (SRA International) to support discussion and a common understanding of cultural competency as an evolving field and to identify strategies for addressing the needed research to be undertaken by each Subcommittee.
- May 14, 2013: During the final in-person meeting, each Subcommittee provided an update on their work progress and a firm timeline was set for completion of deliverables from each Subcommittee.

During this period, the Office of Minority Health and Health Disparities held periodic conference call discussions with the two Workgroup Co-Chairs and with chairs of the subcommittees to assist the process in moving forward on its timeline.

Workgroup Co-Chairs, Dr. Lisa Cooper and Mr. Marcos Pesquera presented updated information on the progress of the Workgroup to the Maryland Health Quality and Cost Council on December 7, 2012, March 18, 2013, and September 13, 2013.

Throughout this process, each Subcommittee coordinated several electronic meetings and teleconferences in order to continue progress with the duties of their charge and work toward a goal of producing a Subcommittee report with their findings. Subcommittee action steps were:

- Conducted literature searches to identify existing local, state and national standards, research, programs and processes relevant to each charge;
- Queried local programs, academic experts and others outside of the Workgroup and subcommittee membership for information on cultural, linguistic and health literacy competency related to each charge;
- Reviewed, examined and considered all materials collected in search of evidence-based or promising practices, and existing opportunities and resources relevant to their respective charges; and
- Conducted careful consideration of materials and the opinion of Subcommittee members to draft reports that described their exploration and presented recommendations to the full Workgroup. The Subcommittees' submission included the individual subcommittee reports with descriptions of their work, lists of members, and numerous appendices.

The staff of the Office of Minority Health and Health Disparities and the Maryland Health Care Commission took all of this material into consideration. Additional input was obtained from the Statewide Health Disparities Collaborative meeting on September 18, 2013, from the Workgroup Co-Chairs, Dr. Lisa Cooper and Mr. Marcos Pesquera, and from additional field work, and drafted into this report for presentation to the Maryland Health Quality and Cost Council. This report is a composite of all work that was completed. It has 14 recommendations.

III. WORKGROUP FINDINGS AND RECOMMENDATIONS

A. Charge 1: Feasibility/Desirability of Reporting & Reimbursement Linkage

1. The Legislative Charge:

"Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;"

This charge contains the following four distinct components to be addressed:

1. Examine **Desirability** of incorporating standards into **Reporting.**
2. Examine **Desirability** of incorporating standards into **Tiered Reimbursement.**
3. Examine **Feasibility** of incorporating standards into **Reporting.**
4. Examine **Feasibility** of incorporating standards into **Tiered Reimbursement.**

2. Findings:

1. Desirability of Incorporating Standards into Reporting - YES

The desirability of incorporating standards into reporting by health care providers derives from evidence that cultural and linguistic competency in clinical care results in benefits to the triple aim of healthcare (1): improved patient experience of care, improved population health, and reduced per-capita cost. The desirability of incorporating standards is also supported by the consensus of expert organizations advocating culturally and linguistically competent care and advocating training of health care professionals in those competencies.

Evidence for Cultural Competency Benefits: Several systematic reviews have documented the benefits of culturally and linguistically competent care (2) (3) (4) (5). The table below provides selected examples of the evidence that culturally linguistically-competent care leads to improved outcomes.

Woerner, L., et al. Project (¡EXITO!): success through diversity and universality for outcomes improvement among Hispanic home care patients. Nurs Outlook. 2009 Sep-Oct; 57(5): 266-73.	
Setting	Hispanic home care patients.
Intervention	A culturally appropriate nursing home care program was developing use of the Leininger Sunrise Enabler approach for Hispanic patients.
Usual Care	Same subjects prior to the implementation of the intervention
Result	Home nursing care utilizing the culturally appropriate program reduced acute hospitalization and emergency care visits. Additionally, patients in the culturally appropriate nursing program had improved medication management, and greater nursing care satisfaction.

Jacobs, E. A., et al. The impact of an enhanced interpreter service intervention on hospital costs and patients satisfaction. J Gen Intern Med. 2007 Nov; 22 Suppl 2:306-11.	
Setting	Public hospital, inpatient Internal Medicine service
Intervention	Enhanced interpreter service using a trained Spanish medical interpreter.
Usual Care	No interpreter services or use of ad hoc interpreters, telephonic interpreters, or the usual hospital interpreter service.
Result	No significant impact of the enhanced interpreter service on measured outcomes (satisfaction with nursing, satisfaction with physicians, satisfaction with hospital stay) for Spanish-speaking patients. Spanish-speaking patients who had a Spanish-speaking physician reported greater satisfaction with physician care and the overall hospital stay than patients with usual care. Spanish –speaking patients who had a Spanish-speaking attending had significantly fewer return ED visits after discharge.

Enriquez, M., et al. Impact of a bilingual/bicultural care team on HIV-related health outcomes. J Assoc Nurses AIDS Care. 2008 Jul-Aug;19(4):295-301.	
Setting	Academic HIV specialty clinic, HIV + Hispanic/Latino adults.
Intervention	A bilingual/bicultural care team was developed and used in the second year of the study.
Usual Care	Usual care (1st year of study) was a non-bilingual/bicultural care team.
Result	In the year after the implementation of the bilingual/bicultural care team, there were more clinic visits per patient than the year prior to the implementation of the care team. Additionally, in the year after implementation of the care team, patients were more likely to have suppressed HIV viral loads <50 copies/ml than the year before the bilingual/bicultural care team was implemented.

Guerrero, E.G. et al. Do cultural and linguistic competence matter in Latinos' completion of mandated substance abuse treatment? Subst Abuse Treat Prev Policy. 2012 Aug 16;7:34.	
Setting	Publically funded treatment programs contracted through the criminal justice system.
Intervention	No intervention arm; observational study.
Usual Care	Existing health care system.
Result	5,150 first-time Latino clients were placed within 48 treatment programs to assess whether culturally and linguistically responsive contexts improve substance abuse treatment adherence. Programs that routinely offered cultural and linguistic services, most importantly Spanish-language translation, were associated with a higher likelihood of patients completing the mandated treatment.

Slean, G.R., et al. Aspects of culturally competent care are associated with less emotional burden among patients with diabetes. Med Care. 2012 Sep; 50(9 Suppl 2):S69-73.	
Setting	Safety-net clinics in two different cities.
Intervention	No intervention arm; observational study
Usual Care	Existing health care system.
Result	502 ethnically diverse patients with diabetes were interviewed to determine if aspects of culturally competent care were associated with the emotional burden of diabetes distress. Patients who reported optimal doctor communication-positive behaviors and optimal trust were associated with lower emotional burden of diabetes distress. Doctor communication- health promotion communication was not associated with emotional burden of diabetes distress.

Fernandez, A., et al. Associations between aspects of culturally competent care and clinical outcomes among patients with diabetes. Med Care. 2012 Sep; 50(9 Suppl 2): S74-9.	
Setting	Urban safety net clinics in two different cities.
Intervention	No intervention arm.
Usual Care	No usual source of care.
Result	Patients were surveyed and chart reviews were conducted on 600 patients with type 2 diabetes and a primary care physician. Patients who reported having high trust in their physician were more likely to have a lower likelihood of poor glycemic control among safety net population patients with diabetes. Doctor communication behavior was not associated with a lower likelihood of poor glycemic control in this safety net population with diabetes.

McEwen, M.M., et al. Type 2 diabetes self-management social support intervention at the U.S.-Mexico border. Public Health Nurs. 2010 Jul-Aug; 27(4):310-9.	
Setting	Community in the Arizona-Sonora, Mexico border region.
Intervention	Culturally-tailored diabetes self-management social support intervention for Mexican American adults with type 2 diabetes living on U.S.- Mexico border. Intervention was developed by a bilingual, bicultural certified diabetes educator and a nurse researcher.
Usual Care	Same subjects prior to the implementation of the intervention.
Result	The culturally tailored intervention was significantly associated with increases in self-care regarding diet, exercise, foot care and increases in overall diabetes self-care. Intervention also decreased diabetes regimen distress and increased diabetes knowledge. The largest effect size observed was the reduction of diabetes regimen distress following the intervention. Physiologic diabetes outcomes did not significantly change following the intervention.

Zeh, P., et al. The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review. Diabet Med. 2012 Oct; 29(10):1237-52.	
Setting	11 studies included- variety of settings with a range of service providers.
Intervention	Varying range of culturally competent interventions- 7 highly culturally competent, 4 moderately culturally competent.
Usual Care	Non-intervention care
Result	Across ten of the studies reviewed, structured interventions that were tailored to ethnic minority groups by means of integrating elements of culture, language, religion, and health literacy skills into practice were found to produce a positive impact on a range of patient-important outcomes.

Michalopoulou, G., et al. Implementing Ask Me 3 to improve African American patient satisfaction and perceptions of physician cultural competency. J Cult Divers. 2010 Summer; 17(2):62-7.	
Setting	Physician offices, African American patients.
Intervention	African American intervention participants received the “Ask Me 3” pamphlet before a visit with a physician. This pamphlet encourages patients to ask their physicians questions during the medical appointment.
Usual Care	African American control patients did not receive the Ask Me 3 pamphlet.
Result	Intervention participants who saw their regular physician during the appointment reported higher satisfaction than controls. All intervention participants reported that they found the questions in the pamphlet helpful, and reported knowing more about their medical condition after their visit.

Flicker, S.M., et al. Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. J Fam Psychol. 2008 Jun; 22(3):439-47.	
Setting	Family therapist offices, Hispanic and Anglo substance-abusing adolescents.
Intervention	Adolescents were ethnically matched with family therapists.
Usual Care	Anglo and Hispanic adolescents were seen by Anglo family therapists.
Result	Hispanic adolescents, when ethnically matched with a Hispanic family therapist, had greater decreases in substance use compared to Hispanic adolescents who were matched with an Anglo family therapist. Ethnic matching did not significantly affect substance abuse treatment for Anglo patients.

Sarver, J., et al. Effect of language barriers on follow-up appointments after an emergency department visit. J Gen Intern Med. 2000 Apr; 15(4):256-64.	
Setting	Urban hospital emergency room with English and Spanish-speaking patients.
Intervention	Not an intervention. Possible conditions: 1) language-concordant provider, 2) interpreter used, or 3) interpreter needed but not used.
Usual Care	All three conditions were variants of usual care
Result	Spanish-speaking patients who used an interpreter (could be a family member) or reported that they did not have an interpreter when they thought one was necessary were significantly less likely to be given a referral for a follow-up appointment after the ED visit than Spanish-speaking patients who had a language-concordant physician. Intervention groups were not significantly associated with follow-up appointment compliance.

Basáñez , T., et al. Ethnic group's perception of physicians' attentiveness: implications for health and obesity. Psychol Health Med. 2013; 18(1) 37-46.	
Setting	Variables from the Health Tracking Household Survey 2007 were analyzed to determine if perceived physician attentiveness mediated the relationship between physician health recommendations and patient health status.
Intervention	No intervention arm; observational study
Usual Care	Existing health care system.
Result	Hispanics and African Americans were significantly less likely to perceive their physicians as attentive to their health needs compared to Caucasian patients. Doctors' recommendations for diet and exercise did not significantly affect patients' body mass index for any of the ethnic groups.

Cooper LA, et al. Comparative effectiveness of standard versus patient-centered collaborative care interventions for depression among African Americans in primary care settings: the BRIDGE Study. Health Serv Res. 2013 Feb;48(1):150-74.	
Setting	10 urban community-based primary care practices in Maryland and Delaware
Intervention	patient-centered, culturally tailored collaborative care for African Americans with depression
Comparison Group	State-of-the-art non-tailored collaborative care for depression
Results	Patients in both groups showed statistically significant improvements in depression symptom levels and mental health functioning over 12 months. Traditional mental health treatment rates increased among non-tailored but not culturally-tailored patients. However, culturally-tailored patients had higher adherence to care management visits and rated their care manager as more helpful at identifying their concerns and helping them adhere to treatment.

Endorsements of Cultural Competency: The following table summarizes documents from leading health and healthcare entities supporting cultural competency in clinical care:

Health Entity:	Document:	Statement:
US HHS: Office of Minority Health (OMH)	Website for *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (6)	"Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes."
US HHS: Center for Medicare and Medicaid Services (CMS)	Medicare Learning Network (MLN) Matters Number SE0621 *Cultural Competency: A National Health Concern* (7)	"To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS's Quality Improvement Organizations (QIOs) are working with healthcare providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (web-based) program *A Family Physician's Practical Guide to Culturally Competent Care* to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the Guide as the "Program of Choice" for health care provider cultural competency education."
US HHS: Agency for Healthcare Research and Quality (AHRQ)	*About the CAHPS Cultural Competence Item Set*. Document No. 2312, (2012) (8)	"To be culturally competent, health care providers have to employ various interpersonal and organizational strategies that bridge barriers to communication and understanding that stem from racial, ethnic, cultural, and linguistic differences. In the winter of 2011, the CAHPS Consortium adopted a new set of supplemental items for the CAHPS Clinician & Group Surveys that focus on assessing the cultural competence of health care providers from the patient's perspective."

Health Entity:	Document:	Statement:
US HHS: National Institutes of Health (NIH)	NIH *Clear Communication* webpage (9)	"Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground."
Institute of Medicine (IOM)	*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) (10)	"Cultural competence may be defined as the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences…three strategic approaches include direct services, cultural homophilly, and institutional accommodations." (pp.554-555) **Recommendation 5-8:** Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice. **Recommendation 5-9:** Support the use of interpretation services where community need exists. **Recommendation 6-1:** Integrate cross-cultural education into the training of all current and future health professionals.
Association of American Medical Colleges (AMCC)	*Cultural Competence Education* (2005) (11)	"In 2000, the Liaison Committee on Medical Education (LCME) introduced the following standard for cultural competence: 'The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.'"

Health Entity:	**Document:**	**Statement:**
American Medical Association (AMA)	*Cultural Competence Compendium* (1999) (12)	(From the Back Cover) "The Cultural Competence Compendium is a resource for physicians in identifying issues surrounded different populations - and learning to examine their own issues as well - so that the care we as physicians provide is the right care for each and every patient we see and the highest quality of care for every patient."
Heath Research and Educational Trust *(of the American Hospital Association)*	*Becoming a Culturally Competent Health Care Organization* (2013) (13)	"It is imperative that hospitals and health care systems understand not only the diverse patients and communities they serve but also the benefits of becoming a culturally competent organization. Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. To improve understanding of diverse cultures, hospitals and care systems should seek advice from individuals and groups in the communities they serve. These constituencies can help hospitals and care systems develop educational materials, increase patient access to services and improve health care literacy."
The Joint Commission	*Advancing Effective Communication, Cultural Competence, and Patient-and Family Centered Care: A Roadmap for Hospitals* (2010) (14)	"The nation's hospitals traditionally focus on meeting the clinical needs of their patients; they seek to prevent errors and avoid inaccuracies that negatively impact the safety and quality of care. However, patients also have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. A growing body of research documents that a variety of patient populations experience decreased patient safety, poorer health outcomes, and lower quality care based on race, ethnicity, language, disability, and sexual orientation."

Health Entity:	**Document:**	**Statement:**
National Committee for Quality Assurance (NCQA)	NCQA *Multicultural Health Care Distinction* web page (15)	"Cultural competency is a necessary component of a high quality health care system. NCQA's Multicultural Health Care (MHC) offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. The Multicultural Health Care Distinction evaluates organizations, such as health plans, wellness, disease management and managed behavioral health organizations through use of an evidence-based set of requirements."
National Quality Forum (NQF)	*A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (2009) (16)	"The National Quality Forum (NQF), an organization dedicated to improving healthcare quality, has endorsed 45 practices to guide healthcare systems in providing care that is culturally appropriate and patient centered. This report presents those practices along with a comprehensive framework for measuring and reporting cultural competency, covering issues such as communication, community engagement and workforce training, and providing healthcare systems with practices they can implement to help reduce persistent disparities in healthcare and create higher-quality, more patient-centered care."
National Association of Social Workers	*Code of Ethics of the National Association of Social Workers* (2008) (17)	1.05 Cultural Competence and Social Diversity. "1. Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures. 2. Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups. 3. Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

Health Entity:	Document:	Statement:
Council on Social Work Education	*Education Policy Accreditation Standard on Cultural Competence* (2012) (18)	Educational Policy 2.1.4 – Engage Diversity and Difference in Practice. "Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim."
Maryland Health Care Commission (MHCC)	Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency* Assessment (RELICC) (19)	In 2013, the MHCC collaborated with the private, commercial carriers operating in the State during the development phase for the Maryland RELICC Assessment. RELICC is a quality and performance measurement tool that was customized for the State of Maryland by the National Business Coalition on Health and the Mid-Atlantic Business Group on Health, with input from Maryland's private, commercial carriers. The initial year of RELICC implementation is already underway by Maryland's carriers with health benefit plans that are required to report on a variety of quality and performance metrics on issues surrounding race/ethnicity, language, interpreter need, and cultural competency.

There is evidence that culturally and linguistically competent care improves triple aim outcomes. There is also broad consensus among leading health entities that cultural and linguistic competency is beneficial in health care. The desirability of having a culturally and linguistically competent health care system in Maryland derives from this evidence and these expert opinions, and is amplified by the high racial and ethnic diversity of the State (45.3% minority in the 2010 census and over 50% minority projected before 2020). Assuring that Maryland is moving toward a more culturally and linguistically competent health care system requires measuring that competence. Therefore, incorporating cultural and linguistic competency standards into the quality reporting by providers and health care organizations is desirable, and should be pursued.

2. Desirability of Incorporating Standards into Tiered Reimbursement - YES

Having established the desirability of having a culturally and linguistically competent health care system in Maryland, it is clear that efforts which promote, enable, and incentivize improvements in cultural and linguistic competency are also desirable to reach that goal. Therefore, it is desirable to use incentives based on reimbursement as one means to promote improvements in cultural and linguistic competency. Reimbursement incentives can be based on cultural and linguistic competency training and performance to the extent that training is meaningful and performance can be accurately measured in a manner that is fair to all providers and systems. This is the question of feasibility, which is addressed below.

3. Feasibility of Incorporating Standards into Reporting - YES

The workgroup considered two components to the question of whether incorporating standards for cultural and linguistic competency into reporting by health care providers is feasible:

- Are there currently standards for cultural and linguistic competence that are operationalized for measurement and assessment of:
    - Medical and behavioral health providers in the clinical setting?
    - Health care systems at the organizational level?
- Are there other states, or are there health care related entities, that are currently and successfully utilizing cultural and linguistic competence standards as part of provider, plan and institutional quality reporting?

Clinically Operationalized Standards for Cultural Competency

The Subcommittee working on this charge reviewed several models of cultural competency standards (see appendix 1). Two sets of standards that emerged from that review as the most suitable for measurement and assessment in the clinical setting were:

Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency* Assessment (RELICC) (19): This new quality measurement tool was fielded as a pilot program for 2013 quality and performance reporting by commercial health benefit plans in Maryland. Plan performance is evaluated along several criteria including:

- Demographics – Important to understand member, provider, and plan staff demographics.
- Data Use by Plans – Important to understand how the collected data is used by plan staff:
    - Assess adequacy of language assistance to meet members' needs
    - Calculate HEDIS or other clinical quality and performance measures by race, ethnicity, or language
    - Calculate CAHPS or other measures of member experience by race, ethnicity, or language
    - Identify areas for quality improvement

    - Share provider information with enrollees to enable them to select concordant clinicians
    - Share information with provider network to assist them in providing language assistance and culturally competent care
    - Set goals (develop targets for improving minority outcomes and reducing measured disparities in preventive or diagnostic care)
    - Develop disease management or other outreach programs that are culturally sensitive

- Member Language Support – Important to understand type of support provided and its impact.
- Delivery of Culturally Competent Care – Important to understand strategies being employed.
- Other RELICC Information – Important to understand additional organizational innovations.

AHRQ's CAHPS *Survey Cultural Competence Item Set* (8): The Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Health Plans and Systems (CAHPS) *Cultural Competence Item Set* consists of supplemental items designed for use with the CAHPS Clinician and Group Survey. The 34-item supplemental survey is completed by a patient and addresses the cultural competence of a particular provider. The items address the following five topic areas:

- Patient-Provider (or Doctor) Communication
- Complementary and Alternative Medicine
- Experiences of Discrimination Due to Race/Ethnicity, Insurance, or Language
- Experiences Leading to Trust or Distrust (including Level of Trust)
- Linguistic Competency (Access to Language Services)

Other standards operationalized for provider or organizational assessment include:

NCQA Multicultural Health Care Distinction Program (15): The National Committee for Quality Assurance (NCQA) *Multicultural Health Care Distinction Program* awards this distinction to health plans which meet NCQA's *Multicultural Health Care Standards*. These standards organize 15 elements into five domains of Multicultural Health Care. Those five domains are:

- Race/Ethnicity and Language Data
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Programs
- Reducing Health Care Disparities

Currently, 12 organizations (representing 20 insurance plan products) nationally have achieved this distinction; none of them are organizations operating within Maryland.

The Joint Commission Standards (14): The Joint Commission (formerly Joint Commission on Accreditation of Health Care Organizations or JCAHCO) has incorporated standards regarding cultural and linguistic competency and provider-patient communication in its most recent accreditation standards.

HR.01.04.01 - The hospital provides orientation to staff.

- EP 5: The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.

HR.01.05.03 - Staff participate in ongoing education and training.

- EP 1: Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.
- EP 5: Staff participate in education and training that is specific to the needs of the patient population served by the hospital. Staff participation is documented.

PC.02.01.21 - The hospital effectively communicates with patients when providing care, treatment, and services.

- EP 1: The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care.
- EP 2: The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

PC.02.02.03 - The hospital makes food and nutrition products available to its patients.

- EP 9: When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

PC.02.03.01 - The hospital provides patient education and training based on each patient's needs and abilities.

- EP 1: The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

RC.02.01.01 - The medical record contains information that reflects the patient's care, treatment, and services.

- EP 1: The medical record contains the following demographic information:
  - The patient's language and communication needs, including preferred language for discussing health care
- EP 28: The medical record contains the patient's race and ethnicity.

RI.01.01.03 - The hospital respects the patient's right to receive information in a manner he or she understands.

- EP 1: The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.
- EP 2: The hospital provides language interpreting and translation services.
- EP 3: The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

National Quality Forum (NQF) endorsed practices (16): There are 45 practices overall, 12 of which are captured by the Cultural Competency Implementation Measure (NQF # 1919) (20). These practices include:

- Preferred Practice 3: Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
- Preferred Practice 4: Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
- Preferred practice 8: Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
- Preferred practice 10: Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.
- Preferred practice 12: Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
- Preferred Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.
- Preferred Practice 30: Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.
- Preferred Practice 32: Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
- Preferred Practice 37: Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget categories as modified by HRET), and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

- Preferred Practice 40: Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.

States Requiring Cultural Competency Assessment and Reporting

The following states require NCQA recognition in their Patient Centered Medical Home (PCMH) Programs, which include items regarding Culturally and Linguistically Appropriate Services (CLAS) (see Charge 2):

- Maryland
- Connecticut
- New York
- Utah
- Vermont

Based on the evidence presented above regarding available assessment instruments and the current use of cultural competency assessment and reporting, its feasibility is confirmed.

4. Feasibility of Incorporating Standards into Tiered Reimbursement – EVOLVING

While assessment and reporting of cultural and linguistic competency is ongoing in several states and health care organizations, direct linkage of reimbursement to such assessment has just begun to evolve. Basing eligibility for PCMH status (and its associated share savings incentive payments) on meeting NCQA PCMH accreditation standards (and its criteria regarding multicultural health care) represents the beginning of such linkages, and is in place in several states (see discussion of Charge 2 and table on page 29).

Linkage of reimbursement to cultural and linguistic competency standards is in theory feasible, but to be implemented fairly requires proficient and accurate assessment of cultural competency, and the exercise of care to be sure that a fiscal incentive system does not unfairly penalize providers who care primarily for minority or other disadvantaged populations. Robust and routine systems for cultural and linguistic competency assessment are just now reaching wider dissemination and use. These are a key pre-requisite to the implementation of reimbursement incentives based on such assessment. This is likely the explanation for the scarcity of reimbursement linkages at this time; as cultural and linguistic competency assessment matures, it is logical that reimbursement linkages will follow.

States Reimbursing for Language Services in Medicaid Programs

A report from the National Health Law Program in 2009 (21) identified 13 states and the District of Columbia as reimbursing for language services on a per-encounter basis in their Medicaid programs. The 13 states were Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington and Wyoming. Payments ranged from as low as $0.20 per minute to as much as $3.00 per minute, billed by the minute or by set fractions of hours (per 15 minutes being very common). Some programs had different

rates for different languages (presumably common vs. rare) and for in-person vs. telephonic services. Some programs only reimbursed language services for the fee-for-service enrollees while other programs reimbursed for all enrollees.

In 2012, New York State began reimbursement for language services on a per encounter basis in Medicaid. As one example of a reimbursement model, New York provides no reimbursement for less than 8 minutes of a language service;, pays $11.00 for 8 to 22 minutes of service; and pays $22.00 for more than 22 minutes of services. New York only reimburses for fee-for-service enrollees; and the service is considered a part of the prospective payment for enrollees in managed care (22).

It is clear that per-service reimbursement for language services is in place for many state Medicaid programs. Maryland can use these models to design per-service reimbursement in its Medicaid program and in other health insurance products in Maryland.

Summary of Findings

Cultural and Linguistic Competency assessment and reporting were found to be both feasible and desirable.

Standards for the cultural and linguistic competency performance assessment of medical and behavioral health care providers were found to be currently applied in some settings.

Linking reimbursement to Cultural and Linguistic Competency assessment results was found to be desirable, but its feasibility will require a more broad experience with assessment and reporting.

At least 14 states and the District of Columba reimburse language services on a per service basis in their Medicaid programs, either for their Fee –For-Service enrollees or for all enrollees.

3. Recommendations:

- Integrate the *Maryland RELICC Assessment* quality measurement tool for addressing disparities into the metrics reported in the Maryland *Health Benefit Plan Quality and Performance Report* and in the metrics used to assess the quality of the qualified health plans participating in the State's Health Benefit Exchange, the *Maryland Health Connection.*
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in plan assessment for the Maryland *Health Benefit Plan Quality and Performance Report*. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in assessment of the quality of the State Medicaid MCOs.

- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in the State's program for assessing hospital quality.
- Ensure that third party payors reimburse healthcare organizations and private physician practices for provision of appropriate language services, including qualified bilingual staff and contractual foreign language and sign language interpreters per encounter, rather than as a bundled payment.
- Assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the State is sufficient to begin to link some portion of reimbursement to performance in those competencies.

4. References:

1. Institute for Healthcare Improvement. *The IHI Triple Aim*. Webpage: http://www.ihi.org/offerings/Initiatives/TripleAIM/Pages/default.aspx

2. Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, Smarth C, Jenckes MW, Feuerstein C, Bass EB, Powe NR, Cooper LA. *Cultural competence: a systematic review of health care provider educational interventions*. Med Care. 2005 Apr;43(4):356-73.

3. Fisher TL, Burnet DL, Huang ES, Chin MH, Cagney KA. *Cultural leverage: interventions using culture to narrow racial disparities in health care*. Med CareRes Rev. 2007 Oct;64(5 Suppl):243S-82S.

4. Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock CH 3rd. *Does cultural competency training of health professionals improve patient outcomes?* A systematic review and proposed algorithm for future research. J Gen Intern Med. 2011 Mar;26(3):317-25.

5. Zeh P, Sandhu HK, Cannaby AM, Sturt JA. *The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review*. Diabet Med. 2012 Oct;29(10):1237-52.

6. US Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. Webpage: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

7. US Department of Health and Human Services, Center for Medicare and Medicaid Services. *Cultural Competency: A National Health Concern.* Medicare Learning Network (MLN) Matters Number SE0621. Available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0621.pdf

8. US Department of Health and Human Services, Agency for Healthcare Research and Quality. *About the CAHPS Cultural Competence Item Set*. CAHPS® Clinician & Group Surveys and Instructions, Document No. 2312. May 1, 2012. Available at https://cahps.ahrq.gov/surveys-guidance/item-sets/cultural/2312_About_Cultural_Comp.pdf

9. National Institutes of Health, Office of Communications and Public Liaison. *Clear Communication.* Webpage: http://www.nih.gov/clearcommunication/culturalcompetency.htm

10. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The National Academies Press: Washington: 2003. http://www.nap.edu/catalog.php?record_id=10260

11. Association of American Medical Colleges. *Cultural Competence Education.* Washington: 2005. Available at https://www.aamc.org/download/54338/data/

12. American Medical Association. *Cultural Competence Compendium*. Chicago: 1999. Available at http://www.amazon.com/Cultural-Competence-Compendium-Fraker/dp/1579470505

13. Health Research & Educational Trust. *Becoming a Culturally Competent Health Care Organization*. Chicago: 2013. Accessible at http://www.hpoe.org/becoming-culturally-competentAHA/HRET

14. The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient-and Family Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: 2010. Available at http://www.jointcommission.org/assets/1/6/aroadmapforhospitalsfinalversion727.pdf

15. National Committee for Quality Assurance. *Multicultural Health Care Distinction.* Webpage: http://www.ncqa.org/Programs/OtherPrograms/MulticulturalHealthCareDistinction.aspx

16. National Quality Forum. *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington: 2009. http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

17. National Association of Social Workers. *Code of Ethics of the National Association of Social Workers*. Washington, DC: 2008. http://www.socialworkers.org/pubs/code/default.asp

18. Council on Social Work Education. *Educational Policy and Accreditation Standards*. Alexandria, VA: 2008 (updated 2012). Available at http://www.cswe.org/File.aspx?id=41861

19. Maryland Health Care Commission. *Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment*. See http://mhcc.dhmh.maryland.gov/disparities/Pages/Resources.aspx

20. National Quality Forum. *NQF #1919 Cultural Competency Implementation Measure*. (See http://www.qualityforum.org/Measuring_Performance/ABCs_of_Measurement.aspx

21. Youdelman, M. *Medicaid and SCHIP Reimbursement Models for Language Services*. National Health Law Program: 2009. See http://healthlaw.org/

22. NY State Medicaid Program. *Coverage of Medical Language Interpreter Services*. Webpage: http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-10.htm

B. Charge 2: Feasibility of Incorporating Standards into PCMH Assessment

1. The Charge:

"Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home (PCMH) program and other health care settings."

This charge contains the following three distinct components to be addressed:

1. Examine **Appropriate Standards** for cultural and linguistic competency assessment
2. Examine **Feasibility** of incorporating standards into **PCMH Assessment Programs**
3. **Recommend Criteria and Standards** for PCMH

Standards for other health care settings in general were covered under Charge 1 (page 11)

2. Findings:

1. Examination of Appropriate Standards

This charge substantially overlaps with one component of charge 1 (discussed previously). Several existing national assessment standards and tools that are in current use were discussed under Charge 1. These included the AHRQ CAHPS *Cultural Competence Item Set* (1), the NCQA's *Multicultural Health Care Standards* used to award the NCQA *Multicultural Health Care Distinction* (2), the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (3), the cultural and linguistic competency standards currently incorporated in The Joint Commission's accreditation guidelines (4), and the National Quality Forum's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (5). The existence of vetted national standards with tools developed for clinical care assessment makes it unnecessary for Maryland to develop its own unique set of standards. Adoption (with modification as needed) of these existing standards is preferred.

Particular themes that can be highlighted from the existing standards include a focus on training, language access, and data collection. The following enhancements to current standards are recommended:

Staff Training

- Staff training should include annual cultural, linguistic and health literacy competency training for all staff (both clinical and support staff).
- Staff training should include how to properly collect data to accurately capture race, ethnicity, language, social determinants, sexual orientation, and gender identity, and why the quality of such data is important.

Language Access

- Increase language access, including translation of documents (such as consent forms and patient education materials) into the languages of the population, as well as the provision of services from qualified bilingual staff or trained medical interpreters.
- Assess the competency of multilingual staff and medical interpreters in a standardized manner.
- Address health literacy and plain language communication needs related to medical encounters, patient education materials, etc.
- Measure patient satisfaction/experience in a manner that is inclusive of diverse populations and allows for patient surveys to be administered in languages other than English.
- Stratify patient satisfaction/experience data by race, ethnicity, and language (as well as other demographic data, such as gender identity, sexual orientation, social determinants, etc.).

Data Collection

- Improve the accuracy of race, ethnicity, language, sexual orientation, gender identity, and social determinants data collected by hospitals, clinics and other health organizations and insurers.
- Stratify clinical process measures and outcome measures by race, ethnicity, and language (with future consideration of the inclusion of sexual orientation, gender identity, and social determinants).
- Use continuous quality improvement to reduce disparities in vulnerable populations.

NCQA Patient Centered Medical Home Accreditation: The National Committee for Quality Assurance has an accreditation program for Patient Centered Medical Homes (6). Overall, NCQA assesses 21 elements across six domains in its PCMH certification program:

- Enhance Access/Continuity
- Identify/Manage Patient Populations
- Plan/Manage Care
- Provide Self-Care Support/Community Resources
- Track/Coordinate Care
- Measure/Improve Performance

Performance on this assessment is tiered, with Level 1 recognition being the lowest scoring recognition, and Level 3 being the highest scoring recognition.

Within the domain "Enhance Access/Continuity" there are seven elements; and the sixth element is "Element F: Culturally and Linguistically Appropriate Services". The four factors contained within that element assess whether a practice is:

- Assessing the racial and ethnic diversity of its population
- Assessing the language needs of its population

- Providing interpretation or bilingual services to meet the language needs of its population
- Providing printed materials in the languages of its population

States Indirectly Linking PCMH Incentive Payments to Cultural Competency: Several states have tied achievement of specific levels of NCQA PCMH recognition to receipt of the various incentive payments associated with PCMH status. Some examples are presented in the table below:

State	Linkage of NCQA Recognition to Payments
Maryland (Statewide Multi-Payer PCMH Program)	A practice that is selected to participate in the program will be required to obtain NCQA PPC-PCMH Level 1+ or better recognition by December 31, 2011 and NCQA PPC-PCMH Level 2+ within 18 months of program commencement (7).
Maryland (Care First PCMH Program)	"Care First provides additional quality points in the incentive calculation for practices achieving various levels of NCQA accreditation (8)."
Connecticut (Medicaid)	In order to qualify as a PCMH, a practice must attain NCQA Level 2 or Level 3 PCMH recognition (9).
New York	Two PCMH pilot programs in New York require NCQA PCMH Level 2 or Level 3 recognition (10).
Utah (Children's Health Insurance Program Reauthorization)	"Implementation Measures (factor in determining proportion of at-risk incentive to be paid) – NCQA Patient Centered Medical Home scoring system or modification thereof (11)."
Vermont (Blueprint for Health)	Practices receive enhanced per-member per-month payment that varies by NCQA PCMH recognition score (12).

As can be seen in the table above, in Maryland the statewide multi-payer PCMH program (coordinated by the Maryland Health Care Commission) requires Level 2 or higher NQCA recognition for continued participation in the PCMH program. Care First's PCMH program gives additional quality points in its incentive calculation for higher levels of NCQA recognition.

2. Feasibility of Incorporating Standards into PCMH Assessment Programs

The feasibility and desirability of incorporating cultural and linguistic competency assessment and reporting into healthcare quality assessment was discussed and confirmed in the previous section (Charge 1). This feasibility of provider and practice-level assessment can be extended to Patient Centered Medical Homes. NCQA incorporates cultural and linguistic competency related elements and factors in its PCMH recognition program. Therefore incorporation of cultural and linguistic competency standards into PCMH assessment programs is feasible.

3. Recommendations:

- Maryland's PCMH programs should require or incentivize participating practices to meet the cultural competency standards contained in national PCMH recognition products.
- Maryland's PCMH programs should examine the feasibility of using the AHRQ's CAHPS *Cultural Competence Item Set* for provider-level and practice-level assessment of cultural and linguistic competency. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Maryland's PCMH programs should require or incentivize participating practices to meet the NCQA *Multicultural Health Care Standards* or a similar standard.
- Maryland's PCMH programs should assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the programs is sufficient to begin to link some portion of reimbursement to performance in those competencies.

4. References:

1. US Department of Health and Human Services, Agency for Healthcare Research and Quality. *About the CAHPS Cultural Competence Item Set*. CAHPS® Clinician & Group Surveys and Instructions, Document No. 2312. May 1, 2012. Available at https://cahps.ahrq.gov/surveys-guidance/item-sets/cultural/2312_About_Cultural_Comp.pdf

2. National Committee for Quality Assurance. *Multicultural Health Care Distinction.* Webpage: http://www.ncqa.org/Programs/OtherPrograms/MulticulturalHealthCareDistinction.aspx

3. US Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. Webpage: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

4. The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient-and Family Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: 2010. Available at http://www.jointcommission.org/assets/1/6/aroadmapforhospitalsfinalversion727.pdf

5. National Quality Forum. *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report*. Washington: 2009. http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

6. National Committee for Quality Assurance. *NCQA's Patient-Centered Medical Home (PCMH) 2011 Standards.* July 29, 2013. Available at http://www.ncqa.org/PublicationsProducts/RecognitionProducts/PCMHPublications.aspx

7. Maryland Health Care Commission. Maryland Multi-payer Patient Centered Medical Home Program: Frequently Asked Questions from Primary Care Providers. Available at http://mhcc.maryland.gov/pcmh/faq.aspx.

8. CareFirst. Patient-Centered Medical Home Program: Program Description and Guidelines. May 2011. Available at https://provider.carefirst.com/wcmwps/wcm/connect/52a3c780456e3cdfa7d6afed9a4bbc9e/BOK5423.pdf?MOD=AJPERES&CACHEID=52a3c780456e3cdfa7d6afed9a4bbc9e.

9. Bremby, R.L. *Policy Transmittal 2011-36 Re: New Person-Centered Medical Home Initiative*. Connecticut Medical Assistance Initiative. December 2011. Available at http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PB%202011-84%20New%20Person-Centered%20Medical%20Home%20Initiative.pdf.

10. Burke, C., Weller, W. *Patient-Centered Medical Home Pilot Demonstrations in New York: No Longer a Leap of Faith.* Health Policy Research Center, The Nelson A. Rockefeller Institute of Government. January 2011. Available at http://www.rockinst.org/pdf/health_care/2011-02-03-Patient-Centered_Medical5.pdf.

11. Children's Healthcare Improvement Collaboration. *Proposal for a Utah Children's Medical Home Demonstration*. Utah Pediatric Partnership to Improve Healthcare Quality, University of Utah School of Medicine. 1 December 2010. Available at http://medicine.utah.edu/pediatrics/upiq/chic_chipra/multi-payer_demonstration_proposal.pdf.

12. Department of Vermont Health Access. *Vermont Blueprint For Health Implementation Manual*. Williston, VT. 17 November 2010. Available at http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf.

C. Charge 3: Criteria for Continuing Education in Multicultural Health Care

1. The Charge:

"Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency and health literacy training."

2. Findings:

The desirability of a culturally and linguistically competent health care system in Maryland was confirmed and discussed in reference to Charge 1 of the Workgroup *(see page 11*)

Cultural Competency Training Mandates in other States

Targeting a specific portion of health professional continuing education (CE) credits required for re-licensure toward a particular subject matter is not unusual. For example, Massachusetts requires for physician re-licensure that 2 CE hours be spent studying the Board's recommendations, 2 hours be spent studying end of life care, and 10 hours be spend studying risk management. Physicians prescribing controlled substances must also complete 3 hours of study in effective pain management (1). Therefore targeting some portion of CE requirements to specific types of training is not without precedent.

States with Cultural Competency Licensure Requirements: Some states have already developed cultural and linguistic competency continuing education requirements for health professional re-licensure. Those states and their continuing education requirements for cultural and linguistic competency are summarized in the table below:

State	Cultural Competency Related Continuing Education Requirement
New Jersey	Physicians are required to have 6 hours of cultural competency education as a one-time (i.e. not repeated with each renewal) requirement for licensure. This can be as CME, or if documented, can be fulfilled in medical school or residency. New Jersey mandates this cultural competency training in the medical school curricula of medical schools in New Jersey (2).
Connecticut	Physicians are required to have one contact hour of education or training in cultural competency every two years (3).
Oregon	Health boards are authorized to adopt rules that require licensees to receive cultural competency continuing education. The Oregon Health Authority must develop a list of approved continuing education opportunities. Public universities and colleges may require providers of health services to students to participate in cultural competency CME at least once every two years (4).

State	Cultural Competency Related Continuing Education Requirement
California	All CME courses that have a patient care component and are offered by CME providers in California are required to contain curriculum that includes cultural and linguistic competency (5).
Washington	Health profession boards are authorized to offer continuing education in cultural competency. Health boards are also authorized to require instructors of continuing education programs to integrate cultural competency into their curricula. Each health profession training program in in the state must incorporate cultural competency training into the curriculum (6).

Based on the evidence of and national consensus for culturally and linguistically competent health care, and on the examples of the states listed above in adding cultural competency training requirements for health professional re-licensure, Maryland should begin to require cultural, linguistic, and health literacy competency training for health professional initial licensure and re-licensure. Currently only two health occupation boards in Maryland require such training for re-licensure (the Maryland Board of Examiners of Psychologists and the Maryland Board of Chiropractic and Massage Therapy Examiners).

3. Recommendations:

- Maryland's health profession boards should require that 5% to 10% of the total continuing education requirement for re-licensure be credits in cultural, linguistic, and health literacy competency.
- Maryland's academic medical centers should identify and/or develop appropriate cultural, linguistic and health literacy competency continuing education materials (both classroom curriculum and individual on-line modules) and make them available to Maryland providers.
- Adopt multicultural health care continuing education (CE) requirements that address the following key components:
    - Amount and frequency of training;
    - Approval process for continuing education credits/units;
    - Curricular structure/Navigation;
    - Compliance monitoring.
- Adopt and promote continuing education curricula that address a standard set of suitable learning objectives adapted from "The Cultural Competency and Health Literacy Primer" (2013). The learning objectives should address health care professionals' knowledge and skills related to cultural diversity, health literacy, cross-cultural communication, proper use of interpreters, bias/stereotyping, social determinants of health, and the impact of these factors on health outcomes and health disparities.

- Adopt and promote continuing education curricula that incorporate a focus on inter-professional education (IPE). An IPE approach enables members of different health profession disciplines to collaborate (and to learn from and with each other) in a teamwork-oriented environment, with the goal of providing the highest quality of care for patients and clients.

4. References:

1. Massachusetts Medical Society. *Continuing Medical Education Requirements for Physician License Renewal in Massachusetts*. 2 April 2012. Accessed October 2013. Available at http://www.massmed.org/Continuing-Education-and-Events/Continuing-Medical-Education-Requirements-for-Physician-License-Renewal-in-Massachusetts/#CME_Requirements.

2. New Jersey Board of Medical Examiners. Adopted New Rule N.J.A.C. 13:35-6.25. New Jersey Register, Volume 40, Issue 7: April 7, 2008. Available at http://www.state.nj.us/lps/ca/adoption/bmeado47.htm.

3. Legislative Commissioner's Office. Connecticut General Statue, §20-10b. Continuing medical education: Definitions: contact hours; attestation; record-keeping; exemptions, waivers and extensions; reinstatement of void licenses. Available at http://www.cga.ct.gov/2013/pub/chap_370.htm#sec_20-10b.

4. Oregon State Legislature. HB 2611 A. An act relating to continuing education for health care professionals; creating new provisions; amending ORS 675.140, 675.330, 675.597, 675.805, 676.625, 677.290, 678.170, 679.260, 681.480, 683.290, 684.171, 685.201, 687.071, 688.201 and 688.585; and declaring an emergency. 28 May 2013. Available at https://olis.leg.state.or.us/liz/2013R1/Measures/Text/HB2611/Enrolled.

5. Legislative Counsel's Digest. California Assembly Bill No. 1195, Chapter 514: An act to amend Section 2190.1 of the Business and Professions Code, relating to physicians and surgeons. 4 October 2005. Available at http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_1151-1200/ab_1195_bill_20051004_chaptered.pdf.

6. Washington State Legislature. Revised Code of Washington 43.70.615: Multicultural health awareness and education program- Integration into health professions basic education preparation curriculum. 2006. Available at http://apps.leg.wa.gov/rcw/default.aspx?cite=43.70.615.

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The Maryland Cultural Competency Workgroup recognizes the work of all contributors:

Cultural Competency Workgroup:

- Co-Chairs:
  - **Lisa A. Cooper**, MD, MPH, Director, Johns Hopkins Center to Eliminate Cardiovascular Health Disparities, James F. Fries Professor of Medicine, Johns Hopkins University School of Medicine
  - **Marcos Pesquera**, RPh, MPH, Executive Director, Adventist Healthcare Center on Health Disparities
- 47 Workgroup Members (see following pages)

Subcommittee Co-Chairs:

- Charge One Co-Chairs:
  - **Dr. Yolanda Ogbolu**, Assistant Professor and Deputy Director for the Office of Global Health, University of Maryland School of Nursing
  - **Ms. Scharmaine Robinson**, Chief, Health Benefit Plan Quality and Performance, Maryland Health Care Commission
- Charge Two Co-Chairs :
  - **Dr. Thomas LaVeist**, William C. and Nancy F. Richardson Professor in Health Policy and Director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health
  - **Dr. Earl Ettienne**, Assistant Professor, Howard University College of Pharmacy
- Charge Three Co-Chairs:
  - **Dr. Linda Aldoory**, Director, Center for Health Literacy, University of Maryland College Park, School of Public Health
  - **Dr. Daniel Teraguchi**, Assistant Dean for Student Affairs, Johns Hopkins School of Medicine
- Subcommittee Members (see following pages)

Maryland Office of Minority Health and Health Disparities Staff:

- **Dr. Carlessia A. Hussein**, Director, Office of Minority Health and Health Disparities
- **Dr. David Mann**, Epidemiologist, Office of Minority Health and Health Disparities
- **Ms. Monica McCann**, Workforce Diversity Director, Office of Minority Health and Health Disparities

- **Ms. Kimberly Hiner**, Health Planning Director, Office of Minority Health and Health Disparities
- **Ms. Julia Chen**, Research Analyst, Office of Minority Health and Health Disparities

Maryland Health Care Commission Staff:

- **Mr. Ben Steffen**, Executive Director, Maryland Health Care Commission
- **Ms. Erin Dorrien**, Chief, Government Relations and Special Projects, Maryland Health Care Commission
- **Ms. Scharmaine Robinson**, Chief, Health Benefit Plan Quality and Performance, Maryland Health Care Commission

Staff Support Group:

- Ms. Margot Aronson, Co-Chair, Maryland Clinical Social Work Coalition; VP for Legislation and Advocacy, Greater Washington Society for Clinical Social Work
- Ms. Eileen Dombo, Visiting Assistant Professor, Catholic University School of Social Service
- Ms. Judith Gallant, Co-Chair, Maryland Clinical Social Work Coalition, Private Practice
- Ms. Katherine Garcia, Coordinator, Herschel S. Horowitz Center for Health Literacy, University of Maryland College Park School of Public Health
- Ms. Darci Graves, Sr. Health Education and Policy Specialist, Health Disparities Practice, SRA International, Inc.
- Ms. Cynthia Harris, Faculty and Curriculum Chair, Howard University School of Social Work, and President NASW-DC Metro
- Ms. Laurie Hedlund, Program Manager, Health Care & Wellness - Continuing Education, Frederick Community College
- Mr. Steven Ragsdale, Consultant, Connecting the Dots
- Ms. Angel Shannon, Adult-Gerontological Nurse Practitioner and Research Consultant, University of Maryland
- Mr. Ray Winbush, Director, Institute for Urban Research, Morgan State University

Cultural Competency Workgroup Members by Subcommittee

Subcommittee / Charge 1:

- **Co-Chair - Dr. Yolanda Ogbolu**, Assistant Professor and Deputy Director for the Office of Global Health, University of Maryland School of Nursing
- **Co-Chair - Ms. Scharmaine Robinson**, Chief, Health Benefit Plan Quality and Performance, Maryland Health Care Commission
- Mr. Thomas E. Arthur, President, Thomas E. Arthur and Associates
- Ms. Maria S. Gomez, President and CEO, Mary's Center
- Mr. Jerry Howard, II, Project Manager, The Maryland Center, Bowie State University
- Senator Verna Jones-Rodwell, State Senator - 44th Legislative District, Maryland General Assembly
- Dr. Yemisi (Oluyemisi) Koya, Manager, Communication, Education and Policy, Maryland Board of Physicians
- Ms. Betty Lam, Chief, Montgomery County Health and Human Services, Office of Community Affairs
- Dr. Austria Lavigne Hooks, Medical Director, Aetna U.S. Healthcare Patient Management
- Dr. Susan Leggett-Johnson, Associate Medical Director and Diversity Officer, Mid-Atlantic Permanente Group, PC-Regional Office, Kaiser Permanente
- Ms. Sonia Mora, 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, Maryland Department of Health and Human Services
- Dr. Philip Osteen, Assistant Professor, University of Maryland, Baltimore, School of Social Work
- Dr. Carol Reynolds - Freeman, Medical Director, Potomac Physicians, P.A.
- Dr. William Talley, Assistant Dean, Department Chair, and Professor, University of Maryland Eastern Shore School of Pharmacy and Health Professions
- Dr. Kima Joy Taylor, National Director, Open Society Foundations, Drug Addiction Treatment and Harm Reduction Program
- Ms. Fredette West, Director, African American Health Alliance; Chair, Racial and Ethnic Health Disparities Coalition
- Ms. Aerlande Wontamo, Refugee Reception and Placement - Resettlement Manager, Lutheran Social Services of the National Capital Area
- Dr. Sherman Yen, Asian American Advocate, Asian American Anti-Smoking Foundation

Subcommittee / Charge 2:

- **Co-Chair - Dr. Thomas LaVeist**, William C. and Nancy F. Richardson Professor in Health Policy and Director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health
- **Co-Chair - Dr. Earl Ettienne**, Assistant Professor, Howard University College of Pharmacy
- Ms. Salliann Alborn, CEO, Maryland Community Health System, Community Health Integrated Partnership

- Ms. Cyntrice Bellamy-Mills, Administrator, Behavioral Health Programs, Department of Health and Mental Hygiene, Mental Hygiene Administration
- Mr. Roger S. Clark, Chief Operating Officer, Medical Home Development Group
- Dr. Florence Veronica Deza, Director of Geriatrics, MedStar Franklin Square Medical Center
- Ms. Wendy Friar, Vice President of Community Health, Holy Cross Hospital
- Ms. Dianne Houston-Crockett, Associate Vice President, Health Promotion, Amerigroup Maryland, Inc.
- Dr. Anna Maria Izquierdo-Porrera, Executive Director and Co-Founder, Care For Your Health, Inc.
- Dr. Niharika Khanna, Director, University of Maryland School of Medicine, Maryland Learning Collaborative
- Ms. Sandra Kick, Health Policy Analyst, Maryland Women's Coalition for Health Care Reform
- Dr. Ligia Peralta, Tenured Associate Professor of Pediatrics and Epidemiology, University of Maryland Baltimore School of Medicine
- Ms. Cheri Wilson, Faculty Research Associate, Health Policy and Management Department; Program Director, Culture-Quality-Collaborative (CQC) and Clearview Organizational Assessments-360 (COA360); Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health

Subcommittee / Charge 3:

- **Co-Chair - Dr. Linda Aldoory**, Director, Center for Health Literacy, University of Maryland College Park, School of Public Health
- **Co-Chair - Dr. Daniel Teraguchi**, Assistant Dean for Student Affairs, Johns Hopkins School of Medicine
- Mr. Brandon Batiste, Director, Johns Hopkins Medicine
- Dr. Janice Berry-Edwards, Assistant Professor, Howard University School of Social Work
- Dr. Olivia Carter-Pokras, Associate Professor, Epidemiology, University of Maryland College Park School of Public Health
- Mr. E. Keith Colston, Director, Maryland Commission on Indian Affairs, Governor's Office of Community Initiatives
- Dr. Doris Dzameshie, President, African Immigrants and Senior Citizen Institute
- Dr. Columbus Giles, Medical Director, Delmarva Foundation for Medical Care
- Mr. Larry Gourdine, , Executive Director, Monumental City Medical Society
- Dr. Leslie Grant, Dental Compliance Officer, Maryland State Board of Dental Examiners
- Ms. Cheryl Jones, Director of Outreach, Chesapeake Regional Information System for Our Patients (CRISP)
- Dr. Chimene Liburd, Representative, Maryland Chapter of the American College of Physicians
- Ms. Yolanda Maria Welch Martinez, Chair, Governor's Commission on Hispanic Affairs; Founder & CEO, Respira Medical

- Ms. Monica McCann, Workforce Diversity Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene
- Ms. Lorraine W. Smith, Executive Director, Department of Health and Mental Hygiene Board Examiners of Psychologists
- Dr. Mohammed Younus, Psychiatrist, Catholic Charities, Child and Family Division; Instructor of Psychiatry, Johns Hopkins Hospital

V. GLOSSARY

Terms

Cultural Competency - A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross -cultural situations.

Health Disparities - Differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury or death.

Health Equity - The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Literacy - The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Healthcare Disparities - Difference between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

Linguistic Competency - The capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

Acronyms

AAMC – Association of American Medical Colleges

ACA - Affordable Care Act

AHA – American Hospital Association

AHRQ - Agency for Healthcare Research and Quality

CAHPS - Consumer Assessment of Health Plans and Systems

CDC - Centers for Disease Control and Prevention

CE - Continuing Education

CLAS – National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

CMS – Center for Medicare and Medicaid Services

CSWE – Council on Social Work Education

IPE - Interprofessional Education

HEZ – Health Enterprise Zone

HEDIS – Healthcare Effectiveness Data and Information Set

HRET – Health Research and Educational Trust

MHCC – Maryland Health Care Commission

MHHD - Maryland Office of Minority Health and Health Disparities

MHQCC - Maryland Health Quality and Cost Council

NASW – National Association of Social Workers

NCQA - National Committee for Quality Assurance

NQF – National Quality Forum

PCMH - Patient Centered Medical Home

RELICC – Race/Ethnicity Language Interpreters, and Cultural Competency assessment

VI. APPENDICES

A. Charge 1: Feasibility/Desirability of Reporting & Reimbursement Linkage

B. Charge 2: Feasibility of Incorporating Standards into PCMH Assessment

C. Charge 3: Criteria for Continuing Education in Multicultural Health Care