Performance Measurement Work Group Meeting

6/18/2019

Agenda

- **Leapfrog Update**
- **Timely Topics**
  - MPA 101 and MPA Quality Adjustment
  - Readmission Sub-group Update
- **Strategic Priorities**
  - HSCRC Quality Strategy
  - MHCC Quality Team Overview
  - MDPCP 101; Alignment with Quality Strategy under TCOC Model
  - Summer Priorities

Leapfrog Update

Leapfrog Update: Spring 2019 Release

The Leapfrog Safety Grade uses 28 measures in total, under the following two domains:

- **Process/Structure** – 13 measures (50% of Grade):
  - 5 HCAHPS measures: Nurse Communication, Doctor Communication, Staff Responsiveness, Communication About Medicines, Discharge Information
  - 5 Safe Practices measure (Derived from Leapfrog Voluntary Survey): Leadership Structure and Systems; Culture Measurement, Feedback & Intervention; Identification and Mitigation of Risks & Hazards; Nursing Workforce; Hand Hygiene
  - Computerized Physician Order Entry (CPOE) measure[1]
  - Bar Code Medication Administration (BCMA) measure[1]
  - ICU Physician staffing measure[1]
- **Outcomes** – 15 measures (50% of Grade):
  - 3 CMS HAC measures[2]
  - 7 PSI measures[2]

[1] Derived from Leapfrog Voluntary 2018 Survey or secondarily from American Hospital Association Annual 2018 Survey.

[2] Calculated by MHCC using HSCRC data for Medicare patients the PSI and HAC measures data are from 10/01/2015-06/30/2017 for both the Fall 2018 and Spring 2019 release.

Leapfrog Update: Spring 2019 Release

Grade	Spring 2019	Fall 2018	Fall 2017
A	10 (25%)	8 (20%)	1 (2.27%)
B	11 (27.5%)	11 (27.5%)	7 (15.91%)
C	14 (35%)	14 (35%)	27 (61.36%)
D	5 (12.5%)	7 (17.5%)	8 (18.185)
F	0 (0%)	0 (0%)	1 (2.27%)

▶ 40 hospitals were graded;[1] 34 hospitals participated in the voluntary survey

▶ About 70% of hospitals received the same grade as the Fall 2018

▶ 8 of 10 facilities with A grade received an A grade on the previous release.

▶ 9 facilities improved by 1 letter grade.

▶ 3 facilities declined by 1 letter grade.

▶ This is the second consecutive round with no Fs.

▶ On the PSI measures, Maryland performed on par with the nation

▶ Maryland ranked 30th out of 47 states/DC, which was an improved ranking from the Fall of 2018 where Maryland ranked 38th

[1]Hospitals that did not receive a grade are Atlantic General, Laurel Regional, McCready, Shore Medical Easton/Dorchester/Chestertown, UMD Ortho & Rehab.

MPA 101

Overview

- ▶ **What is it?**
  - ▶ A scaled adjustment for each hospital based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark

- ▶ **Objectives**
  - ▶ Brings direct accountability to individual hospitals on Medicare TCOC performance
  - ▶ Links non-hospital costs and quality measures to the TCOC Model, allowing participating clinicians to be eligible for bonuses under MACRA

How is TCOC performance measured?

- Based on Medicare per beneficiary per year cost (PBPY) for all Maryland Medicare beneficiaries with both Part A and Part B enrollment
- Aims to attribute beneficiaries and their TCOC to hospitals based on relationships between beneficiaries and providers, and providers and hospitals
- Differs from most HSCRC other policies that are based on hospital use

Summary Diagram of MPA Y2 Attribution

Goal: Develop an attribution algorithm that accurately captures the beneficiary-to-provider and provider-to-hospital relationships.

Step:

01

Beneficiary Attribution

1A. MDPCP-Actual   *1B. ACO-Like*   *1C. PCP-Like*

02

Provider-to-Hospital Linkage

2A. MDPCP Provider   *2B. ACO Provider to*   *2C. Employment*   *2D. Referral Pattern*
to CTO Hospital   *ACO Hospital*   *Linkage*   *Linkage*

03

Remaining Beneficiary Geographic Attribution

How is performance assessed?

- Improvement only in RY2020 and RY2021
  a. Exploring attainment in future years
- Benchmark set at national Medicare growth rate for the performance year less a Trend Factor of 0.33%
  a. Calculate hospital-specific target as prior year performance with benchmark applied
- Score calculation
  a. (Hospital-specific target – Hospital performance) / Hospital-specific target
  b. Result x (1 + **Quality Adjustment**)

MPA Quality Adjustment

► Rationale
  ► Payments under an Advanced APM model must have at least some portion at risk for quality
  ► Because the MPA connects the hospital model to the physicians for MACRA purposes, the MPA must include a quality adjustment

► Other requirements
  ► Must be aligned with measures in the Merit-Based Incentive Payment System (MIPS) to the extent possible

► Required to include, at minimum:
  ► Adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC)

Translation to revenue adjustment

- ## RY2020:
  - Maximum revenue at risk: +/-0.5% of federal Medicare revenue
  - Maximum performance thresholds: 2%
- ## RY2021
  - Maximum revenue at risk: +/- 1% of federal Medicare revenue
  - Maximum performance thresholds: 3%

Medicare TCOC Performance: $9,700 $10,300

Max reward of +1%

Scaled reward

High bound +1%

Medicare Performance Adjustment

3%

-3%

Scaled penalty

Max penalty of -1%

Low bound -1%

Numbers are examples, and are not illustrative of actual benchmarks

Calculation Example – Carroll County

Line	Calculation	Value
Carroll Target	CY17 PBPY x (1+Target %)	$12,252
MPA Impact before Quality and Thresholds	(Carroll Target - Carroll CY18 Actual)/Carroll Target	2.38%
Total Quality Adjustment	RRIP + MHAC Adjustment	-0.26%
MPA Impact before Thresholds	MPA Impact before Quality x (1+Total Quality Adjustment)	2.37%
MPA Impact after Threshold	Max of 2.0% either direction (3% in Y2)	2.00%
MPA Adjustment	MPA Impact x (0.5% / 2.0%), (1% and 3% in Year 2)	0.50%
MPA Reference Dollars	MPA Adjustment x Hospital CY18 FFS Payments for Maryland Residents	$430,289
Hospital Specific MPA Factor	**1 + MPA Reference Dollars/Hospital CY18 FFS Payments**	**1.00477**

Inputs		
CY17 Total MPA Attributed PBPY	$11,869	
CY18 Total MPA Attributed PBPY	$11,960	
RY20 RRIP revenue adjustment*	-0.48%	
RY20 MHAC revenue adjustment*	0.22%	
Hospital CY18 FFS Payments for Maryland Residents	$86,057,894	
Hospital CY18 FFS Payments	$90,132,404	
National Growth %	3.56%	
Target % (National - 0.33%)	3.23%	

MPA Quality Adjustment - Future

PMWG Input on MPA Quality Adjustment

- ▶ **For Y3 (RY2022) MPA Policy, considering new measures**
  - ▶ Opportunity to utilize Medicare claims data and other data sources to capture quality of care not possible in case-mix data
- ▶ **As always, use validated measures whenever possible**
- ▶ **New measures should be aligned with TCOC goals**
  - ▶ Total Cost of Care Model requires a focus on population health improvement for all Marylanders
  - ▶ Align with Maryland Primary Care Program (MDPCP)
  - ▶ Align with Bold Improvement Goals (BIGs)
  - ▶ Align with outcomes based credits

PMWG input needed

- RY2022 MPA Policy is written and presented at Commission in Late Fall 2019.
    - Need input on recommended quality/population health measures prior to late fall 2019

<div style="border:1px solid #000; background:#3f7f8c; color:white;">

Open questions:

- Should the measures focus on prevention, management, or utilization?
- Should we use measures that are already implemented in our programs or new unique measures that align with existing measures?
- **Which measures should we prioritize feasibility testing and modeling?**

</div>

Example Measures for Consideration

- **Follow-up after discharge (14 days; Medicare)**
  - Concern of RTI evaluation

- **Possible diabetes measures**

Diabetes Prevention (aligns with outcomes-based credit)	Diabetes Management (aligns with GBR and MDPCP)	Diabetes Utilization (aligns with GBR and MDPCP)
Diabetes Incidence	Eye & foot exams	PQIs
BMI Screening & follow up	HbA1C Testing/Control	Readmissions
Diabetes Screening	Nephropathy	Hospitalizations
Well-visits for at risk adults	Follow-up after hospitalization	ED visits
DPP enrollment		

Planned MPA reporting: Diabetes Population Profile

▶ **Goals: Use MPA attribution and CCLF claims data to:**

1. Describe cost and nature of care being delivered to attributed beneficiaries who have the CCW flag for diabetes

2. Identify potential areas of focus for concentrated efforts in this cohort

▶ **Claims data is not sufficiently robust to point to specific gaps in care or measure quality at a patient level and that is not the objective of this module.**

Overall Care Profile - Diabetes

Target Selection Box:
Select One or More MPA Attributed Facilities

Comp Selection Box:
Select One or More MPA Attributed Facilities or State

Note:
Diabetes flag based on the CMS chronic condition warehouse definition

	PY Calendar Year			CY YTD		
	Comp Group	Target Facility(ies)	Variation Indicator	Comp Group	Target Facility(ies)	Variation Indicator
Measures Related to All Attributed Benes						
Claim for DPP per K						
% of Attributed Benes w. Diabetes Flag						
Measures Related to Attributed Benes with Diabetes CCW Flag						
Average # of Diabetes Flagged Benes						
30 day readmission rate						
30 day readmissions per k						
PQI 93 per k						
ED Vists per K						
IP Days per K						
Per Capita Cost						
Per Capita Cost by Care Setting:						
IP						
ED						
.						
Etc.						

DPP = Diabetes Prevention Program (derived from claims) The denominator is the count of hospital's all attributed beneficiaries

Benes with diabetes / All attributed beneficiaries

Values based on number of beneficiaries with diabetes

Definitions TBD

PMWG input needed

▶ RY2022 MPA Policy is written and presented at Commission in Late Fall 2019.

   ▶ Need input on recommended quality/population health measures prior to late fall 2019

<div style="border:2px solid black; background-color:#4a7c8a;">

<u>Open questions:</u>

- Should the measures focus on prevention, management, or utilization?
- Should we use measures that are already implemented in our programs or new unique measures that align with existing measures?
- **Which measures should we prioritize feasibility testing and modeling?**

</div>

Readmission Sub-group Update

Readmission Sub-group Update

Sub-group has met 3 times since February 2019 and has explored the following six topic areas:

1. Benchmarking
    a. MPR Peer Group Hospitals
    b. Peer Groups by County – MEDA Center for Medicare and Commercial
2. Updates to Existing Measure
    a. Ongoing inclusion of AMA Discharges?
    b. Ongoing exclusion of Oncology Cases?
3. Shrinking Denominator/Case-mix Adjustment
    a. Examined whether shrinking denominator is adversely impacting hospitals
    b. Need to consider adequacy of case-mix adjustment

Readmission Sub-group Update

4. Social Determinants of Health – Monitoring and Potentially Risk-Adjusting
   a. Existing SDOH variables (ADI; Payer Status; Race or other Demographic; Z-code or other data capture field)
   b. Measure of Within Hospital Disparities
   c. Risk Adjustment for Known inter-hospital disparities in statewide readmission goal (?)
5. Room for Ongoing Improvement or Attainment-Only Program
   a. Acknowledgment of relatively flat national Medicare readmission rate improvement
   b. Additional attendant scrutiny on comparable nature of distinct patient populations in Attainment-only measure
6. Non-traditional Measure(s) of Readmission
   a. EDAC – Excessive Days in Acute Care (Condition-specific, on CMS Hospital Compare)
   b. eCQM (Electronic Clinical Quality Measure) of Readmissions
   c. Readmission per Capita

Quality Programs Strategic Direction

HSCRC Hospital Quality Strategic Planning

1. Strategic planning sessions with Commissioners to develop critical action items
2. Strategic planning session with CMMI to discuss vision for Maryland quality
3. Contractor procurement with subject matter and stakeholder engagement expertise to help develop strategic plan:
   a. Meet with key internal and external stakeholders, including cross agency Secretary level meetings and routine engagement with Hospital CEO's
   b. Develop and implement a measure evaluation framework to assess the reliability and validity of HSCRC's current performance-based payment measures and methodologies, as well as newly proposed measures and methodologies
   c. Identify and affirm important strategic goals under the TCOC model
   d. Identify strategic objectives and implementation timeline

Commissioner Critical Action Plan - Quality Tasks

			Key	On Track/Complete	Ongoing, with further development needed	Ongoing, with delays or concerns	Stalled, delays and concerns	Off Track	Planned
Critical Actions Timeline				**2018 (Year 0)**	**2019 (Year 1)**	**2020 (Year 2)**	**2021 (Year 3)**	**2022 (Year 4)**	**2023 (Year 5)**
	Task	**Activity**							
1b.	*Develop Bold Improgrement Goals and Quality Program Progression*	Develop targets for existing quality programs for the TCOC model		MHAC Redesign - Complete	Readmissions Subgroup: Evaluate National Peformance Target	Quality-Based Reimbursement Review			
		Evaluate and update quality programs that will be more dramatically modified in TCOC model		MHAC Redesign - Complete; PAU Measurements Subgroup concluded in September	Readmissions Redesign	Quality-Based Reimbursement Review			
		Develop Bold Improvement Goals (BIGs) and bridge with population health goals		Developing work plan and conceptual framework, aligning with population health summit	Implementation into policy	Ongoing implementation as outcomes based credits/BIGs are approved			
		Design hospital programs in alignment with system goals and BIGs			Procure contractor to develop strategic plan	Implement strategic plan			
1c.	*Develop Outcomes-Based Credits for Population Health Improvements*	Annually develop additional performance and cost methodology for new measures by December		Diabetes development and submission	Formal approval diabetes;Opioids, others?	Annual submission of new credit(s)			

Background

State and **HSCRC** Quality Strategy under the All-Payer Model

▶ Focus on **Inpatient Quality Measures**
▶ Transition from **process** → **outcome** measures
▶ Align with national Medicare pay-for-performance programs and quality achievement
▶ Where possible, apply Medicare quality measures to All-Payer claims
▶ Incentive the Transformation of the Healthcare Delivery System via:
  ▶ Population based revenue funding of hospitals (GBR)
  ▶ Pay-for-performance programs with rewards/penalties
  ▶ Infusion of care coordination funding (Infrastructure dollars, Transformation Grants for Regional Partnerships)
  ▶ Non-profit hospital mandate (Community Benefit dollars)
  ▶ Waivers and data (Care Redesign Programs)

All-Payer Model → Total Cost of Care Model

HSCRC, Hospitals, and associated stakeholders (MHA, payers) are no longer the <u>only</u> principal actors

The State and its various initiatives are integral to the success in the Total Cost of Care Model

- ▶ Maryland Department of Health
- ▶ Local Health Departments
- ▶ Maryland Department of Human Resources
- ▶ Maryland Department of Aging

IP Hospital-focused Outcomes are no longer sufficient

- ▶ Population Health metrics and goals need developed
- ▶ Alignment with other State initiatives must be ongoing, must inform Population Health Strategy

State TCOC Strategy

State Quality Strategy Under the TCOC Model: **B**old **I**mprovement **G**oals

▶ Maryland will develop far-reaching, inclusive and statewide Bold Improvement Goals to align community health, provider systems, and other facets of the State's health ecosystem to improve population health and achieve success under the TCOC Model

▶ Development Partners
  ▶ Stakeholder Groups
      ▶ High-Level – Secretary's Vision Group (SVG)
      ▶ Mid-Level – Stakeholder Innovation Group (SIG)
      ▶ Operational – Within-the-state agencies' Friday morning calls (MDH, HSCRC, MHCC), Workgroups
  ▶ State Staff
      ▶ Workgroups – when being implemented into a specific program/policy
      ▶ Commissioners, Leadership, Advisory Boards
  ▶ Subject Matter Experts
  ▶ Others: TBD

How do the BIGs Drive and Produce Change?

Bold Improvement Goals

- Reduce Statewide Diabetes Burden
- "Behavioral Health and Opioid Crisis Response"
- "Senior Health and Quality of Life"
- "Patient-Centered Care and Health Disparities"

What will we achieve?

Achieve 3,5,7-year targets	System and Statewide Alignment	Framework for tying TCOC Model Success to Population Health Improvements

Outputs: What will we get?

1. Communicate Priorities and Methods of Alignment	2. Connect BIG targets and measures to Programs	3. Collaborate and disseminate best practices	4. Share resources and Data	5. Monitor and Evaluate Progress	6. Refine and Update as nec'y

Activities: What will we do?

HSCRC Value-Based Reimbursement Programs and Financial Methodologies	MDPCP Learning Systems and Quality Incentives	State Medicaid Programs and Priorities	MHCC Policies and Quality Reporting	MDH programs and Initiatives (SHIP, LHICs etc.)	Statewide Agencies and Programs	Community-Based Organizations, Payers etc.

Inputs: Where will changes be made?

HSCRC TCOC Strategy

HSCRC Quality Strategy Under the TCOC Model: **Alignment, Alignment, Alignment**

▶ 1) Continue to improve **hospital pay-for-performance programs**
  - ▶ Maintain waivers from CMS Programs
  - ▶ Sustain and improve high quality care under capitated hospital model
  - ▶ Monitor additional types of performance metrics for holistic evaluation of hospital quality

▶ 2) Develop paradigm for including population health metrics into pay for performance and monitoring as well as various HSCRC financial methodology applications
  - ▶ Utilize HSCRC pay for performance expertise to support other state value based initiatives

HSCRC TCOC Strategy: Hospital Quality

1) HSCRC **Hospital** Quality Strategy under the TCOC Model – Pay-for-Performance

▶ Refine existing all-payer hospital **pay-for-performance programs** for Maryland

- ▶ Focus **complications** program to narrower measure set that has greater opportunity for improvement; move to attainment only system
- ▶ Responsibly modernize statewide **readmissions** target
  - ▶ Safeguard against unintended consequences
  - ▶ Consider general utilization incentives in GBR model
  - ▶ Measure and monitor disparities following NQF guidelines
- ▶ Evaluate **Quality Based Reimbursement** program; consider additional metrics
  - ▶ Consider outpatient Quality measures; quality under specific service lines
- ▶ Reform **Potentially Avoidable Utilization** program to reflect greater focus on per capita metrics

1) HSCRC **Hospital** Quality Strategy under the TCOC Model - Beyond P4P

▶Continue to expand **monitoring of all-payer quality outcomes** beyond those used in CMS hospital pay-for-performance programs
  ▶ Monitor and report on **health disparities and healthcare access**
  ▶ Consider approaches to measuring hospital commitments to community benefit investments to improve population health and achieve health equity
  ▶ Maximize all-payer opportunities by focusing on areas of concern like maternal and child health
▶Identify **additional data sources** (e.g. electronic medical records; broader use of CCLF data); optimize use of non-traditional data sources
▶Further invest in quality assurance and coding audits

The chart shows each calendar year, HSCRC is working on multiple rate years: Finalizing, operating, developing

HSCRC Hospital Quality Program Timelines

Onwards 2028 →

Quality Program	Rate Year	2019												2020											
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Example RRIP	RY 20	Reporting ● ✦ Rev. Adj. $ Implement RY20 Rate Order																							
	RY 21	RRIP Policy Administration												Rev. Adj. ● ✦ $ Implement RY20 Rate Order											
	RY 22	Annual Policy Recommendation ☆ ★ Commission Approval												RRIP Operations											
	RY 23	Long-Term Policy Development												Short-term Policy Development											

Symbols/Colors

- ▬ Operations during performance period (e.g., webinars, hospital monthly reporting)
- ▬ Policy Development
- ▭ Ongoing Reporting
- ● HSCRC Data or Results ● CMS Data
- ☆ Commission Review Draft Policy
- ★ Commission Final Approval of Policy
- ✦ Calculation of Revenue Adjustments
- ★ CMS Written Approval
- $ Implementation of Revenue Adjustments in Rate Orders
- ▲ HSCRC Report ▲ CMMI Report

HSCRC TCOC Strategy: Population Health

2) Population Health Focus - Alignment Paradigm

▶ HSCRC in conversations with CMMI; population health focus needed in TCOC model

▶ Use BIGs and Disability-Adjusted Life Year Evaluations to inform Outcome Credits

  ▶ Outcome Credits are one of the driving forces behind additional focus on population health as they are new opportunity to incentivize coordination to improve population health under TCOC

  ▶ Annually submit 1 to 2 outcome credits to CMS for approval

  ▶ Reinforce focus on outcome credits by including related metrics in:

    ▶ HSCRC Quality Programs, with potential goals (RRIP, QBR, PAU, MHAC)

    ▶ Financial Methodology Applications (Rate Sufficiency Reviews through the ICC, Care Redesign, Regional Partnership allotments, MPA)

▶ Use BIGs, Disability-Adjusted Life Year Evaluation, and HSCRC hospital expertise to coordinate on population health with other state actors

  ▶ MDPCP

  ▶ Medicaid MCO Pay-for-Performance

HSCRC Population Health Alignment Paradigm
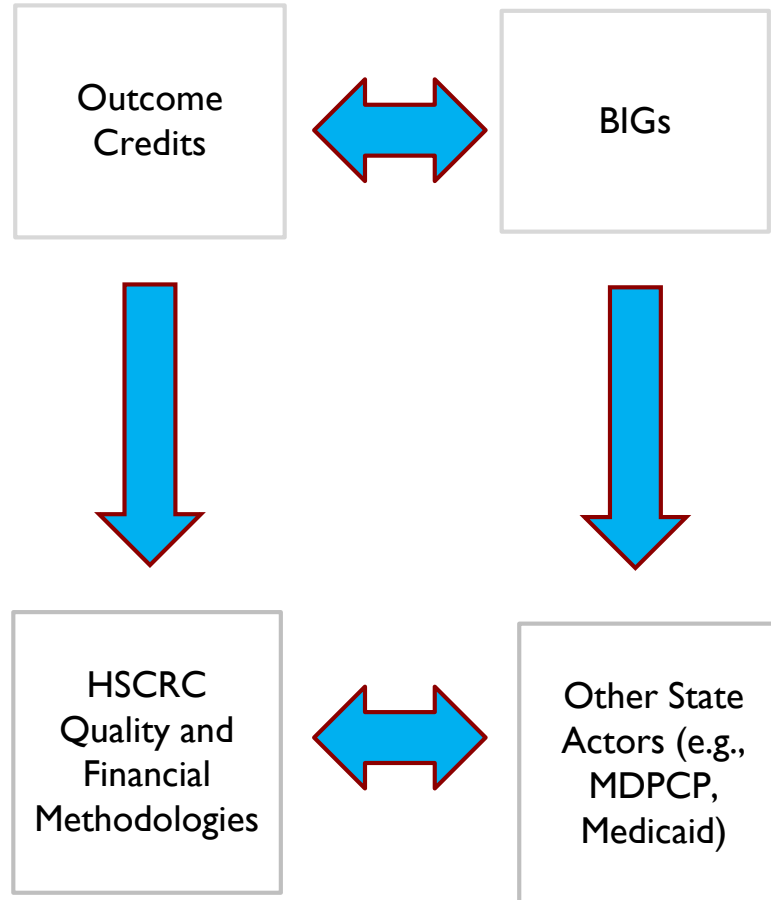
```
┌──────────────┐          ┌──────────────┐
│   Outcome    │  ◄────►  │     BIGs     │
│   Credits    │          │              │
└──────────────┘          └──────────────┘
        │                         │
        ▼                         ▼
┌──────────────┐          ┌──────────────┐
│    HSCRC     │          │ Other State  │
│ Quality and  │  ◄────►  │ Actors (e.g.,│
│  Financial   │          │    MDPCP,    │
│Methodologies │          │  Medicaid)   │
└──────────────┘          └──────────────┘
```
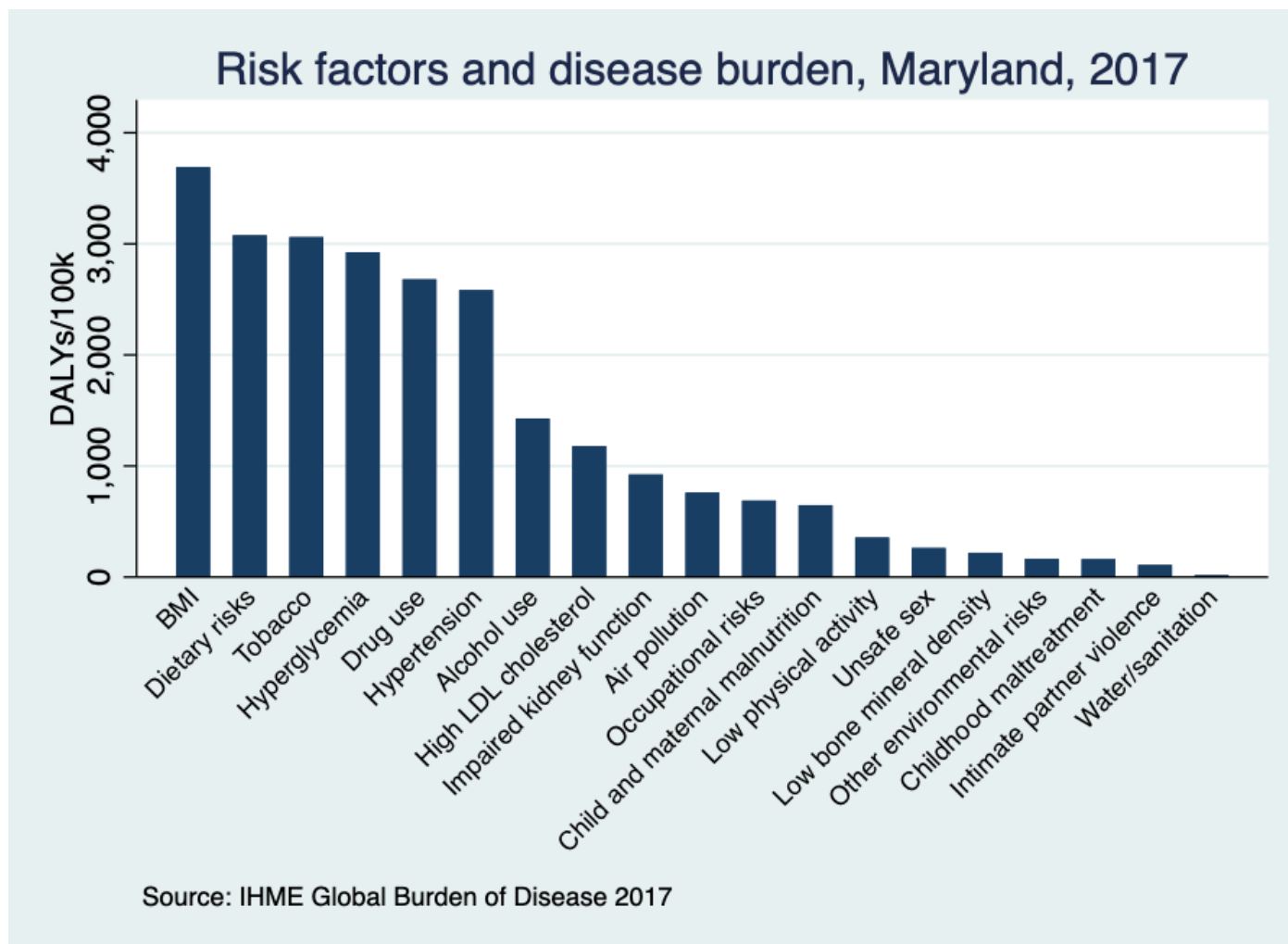
Outcomes Based Credits

What is a disability adjusted life year?

It's a measure of the overall burden of disease – it adds the years of life lost due to early death and years spent living with disability or ill-health together
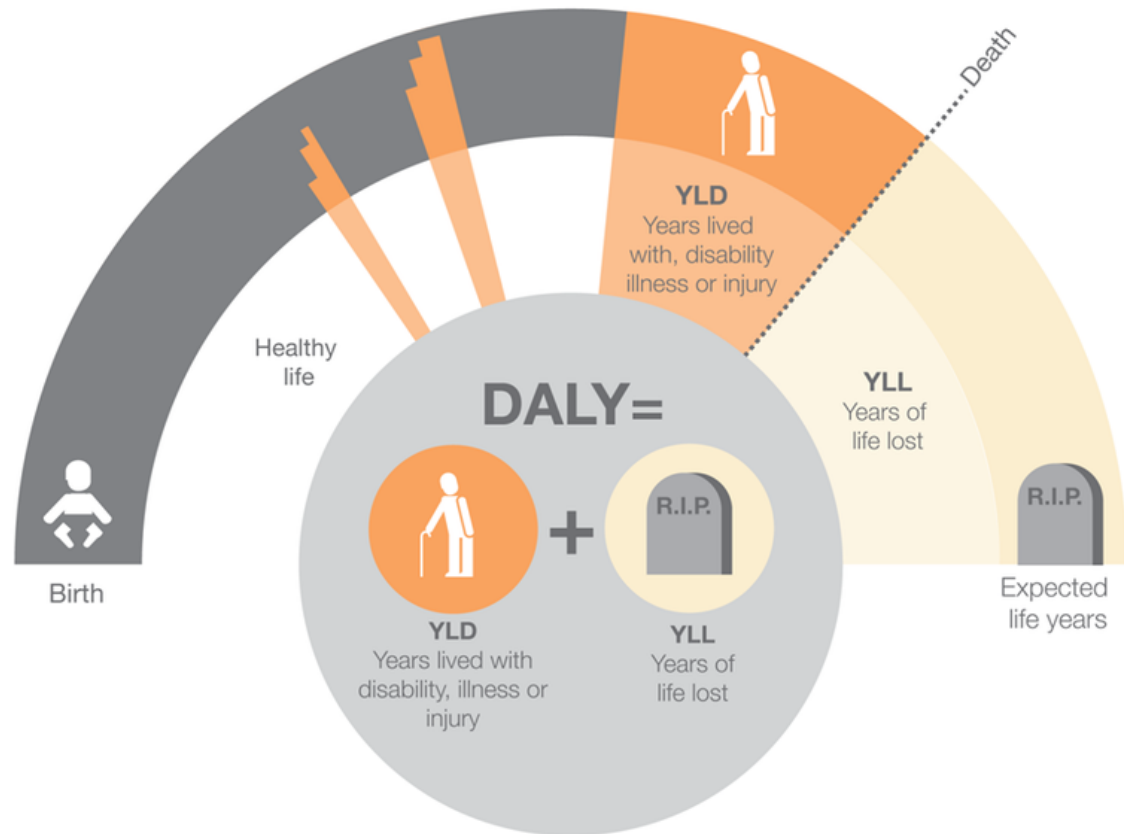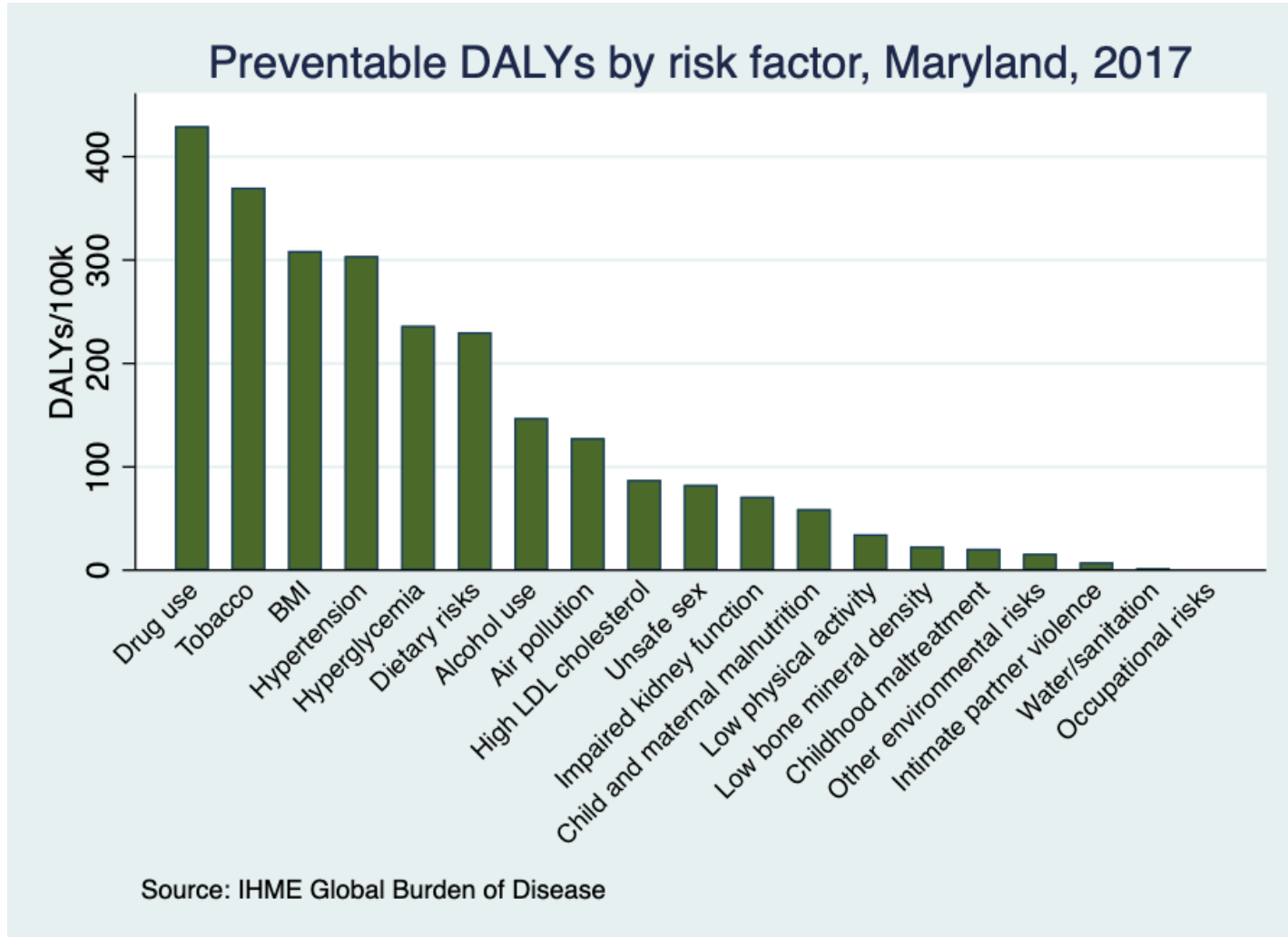
DALYs: Burden of disease in Maryland

Risk factors and disease burden, Maryland, 2017

Source: IHME Global Burden of Disease 2017

DALYs: Opportunities for Improvement

The amount of DALYs improved if Maryland moved up by 10 spots in national rankings

Preventable DALYs by risk factor, Maryland, 2017

Source: IHME Global Burden of Disease

Additional Considerations for Selection/Opportunity

1. Cost/ROI of interventions
2. Emerging public health problems
3. Special populations/target age groups
4. Specific interventions
5. Incidence vs. disability and lifespan
6. Health Disparities
7. Total Cost of Care

Concluding Thoughts

▶ HSCRC will develop a strategic plan, aligning with other state partners, subject matter experts, and stakeholders

▶ Two core tenets of the HSCRC TCOC quality strategy are:

  ▶ Refine hospital pay-for-performance programs to ensure high quality hospital care under the TCOC model

  ▶ Include population health metrics into monitoring reports, pay for performance programs, and various HSCRC financial methodology applications

MHCC Quality Dashboards
(slides will be provided at meeting)

MD-PCP - Overview and Alignment under TCOC Model

(slides provided in separate powerpoint)

Additional Areas of Focus

Additional Areas of Focus

These topics are general updates of areas of focus; specific updates may be coming in the fall/winter

1. Ongoing efforts to incorporate SDOH and Social Resources into reporting
   ▶ CRISP work on capturing data from EMRs
   ▶ Hospital-led work (Infrastructure-funded; RP-funded)
   ▶ Addition of race filters to hospital reports
   ▶ Z-code use in Case-mix
2. PRPA innovation initiatives (Care Redesign, EEP, ECIP, re-vamp of RPs)
3. General non-hospital data sources (CCLF; MDS; OASIS; APCD; other)
4. Quality Reporting and Monitoring for Maternal Health
   ▶ Understanding of existing initiatives
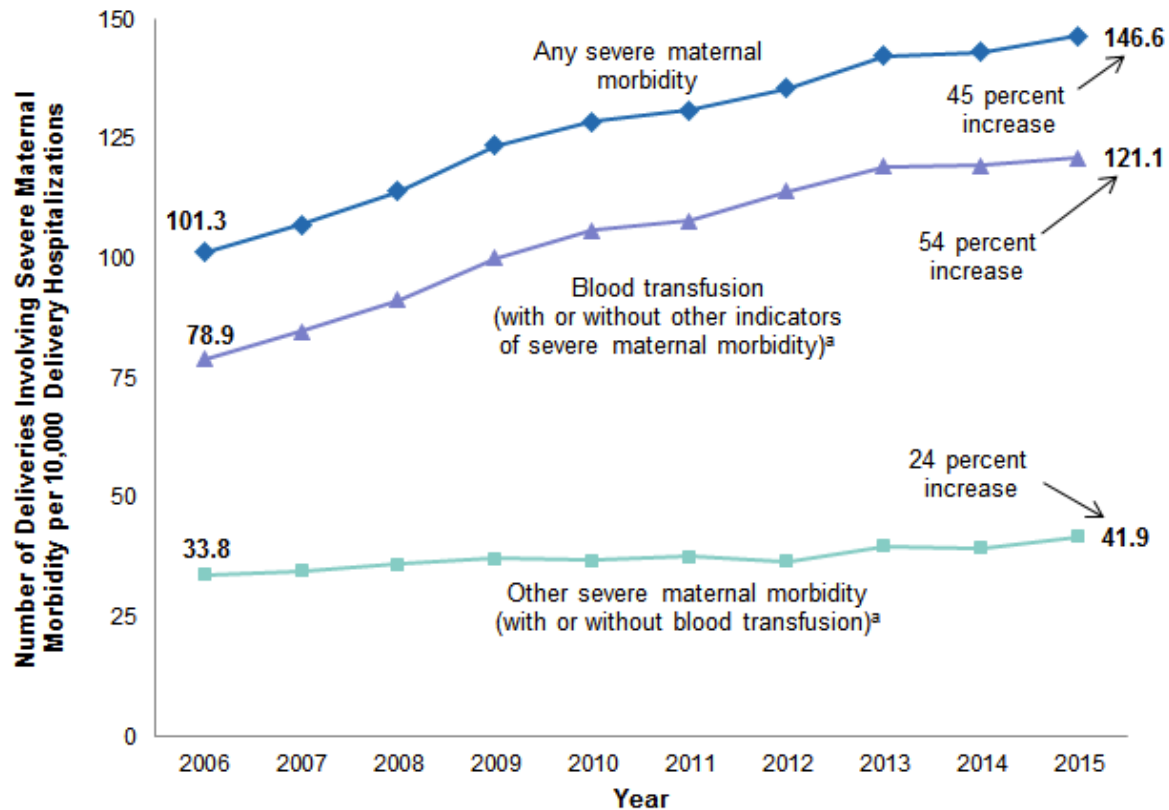   ▶ Legislative Taskforce
      ▶ MHCC Work Group

Maternal Health in US Headlines

- "For Every Woman who Dies in Childbirth in the U.S., 70 more Come Close" – NPR, May 2018
- "America is Failing its Black Mothers" – Harvard Magazine, Winter 2019
- "Hospitals blame moms when childbirth goes wrong. Secret data suggest it's not that simple." – USA Today, March 2019
- "To Keep Women from Dying in Childbirth, Look to California" – NPR, July 2018
- "Addressing Maternal Mortality and Morbidity in California through Public-Private Partnerships" – Health Affairs, September 2018

National Severe Maternal Morbidity

HCUP Graph on National Severe Maternal Morbidity Trends

Figure 1. Trends in delivery hospitalizations involving severe maternal morbidity, 2006-2015

Maternal Health in MDH

▶ **MDH Maternal and Child Bureau** – monitors Maternal and Infant Mortality via FIMR and MMR reports.

▶ **Legislative Focus** – HB520/SB406 – Prenatal and Infant Care Coordination / Prenatal Grant Funding & Task Force

▶ **MHCC** – Presents IQI measures on Quality Reporting website; co-chairs "African American and Rural Community Infant Mortality Study" with MHHD

▶ **Minority Health & Health Disparities** – Co-chairs aforementioned work group; disparities in maternal health outcomes a priority issue area for MHHD

▶ **MD Medicaid** – monitors HEDIS measures of access and utilization of prenatal and post-natal care

▶ **Vital Statistics** – provides data to multiple aforementioned initiatives and work processes

# HSCRC IP Data - An Opportunity to Monitor Maternal Health?

Proposal –

▶ Generate a **monitoring report** of labor and delivery measures to report divergence in process and outcome measures for pregnant women in Maryland
  - ▶ Rely on open-source, publicly available measures
  - ▶ Present static report on CRS Portal in coming seasons
    - ▶ Example measures: Maternal morbidity (transfusion, hysterectomy), c-section rates, disparities

RACE/ETHNICITY

Maternal Mortality - Black

MD: 40.5
U.S.: 47.2

Maternal Mortality - White

MD: 17.6
U.S.: 18.1
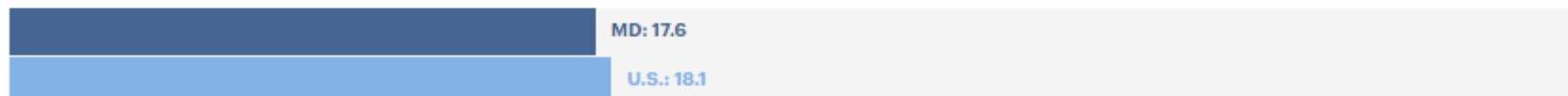
Deaths per 100,000 live births

● CDC WONDER Online Database, Mortality files, 2011-2015

Next Work Group Meeting:

TBD - ENJOY YOUR SUMMER

Quality Webinar - Friday, June 28th

RRIP Sub-group - Tuesday, June 25th