[Natasha Reese-McLaughlin] My name is Natasha McLaughlin, and I'm a senior researcher at Mathematica, and I was part of the Asthma Affinity Group Technical Assistance (TA) Team. And today, I'm joined by my CMS colleague, Jessica Lee, as well as members from two of our state teams, who will share a bit about their Asthma Affinity Group experience. From Texas, we have Susana Peñate, and from California, we have Arlene Silva, Rahel Negash, Helen Lee, and Rosa Reyes. Next slide, please.

Before we begin, I'll go over a few housekeeping items. First, as you'll likely notice, you were all muted upon entry. We ask that you remain on mute. There will be a ten-minute Q&A session at the end of the presentations. Please submit questions using the chat panel. The webinar team will monitor the chat throughout today's presentation, so feel free to ask questions as you have them. You can also use a chat feature to contact our event producer, Derek Mitchell, if you have any technical issues.

At the end of today's webinar, there'll be a pop-up survey. We ask that you kindly take a minute to respond before closing the webinar. And finally, in the next few weeks, a recording of the presentation and the slides will be available on Medicaid.gov. We will send an email once they are posted. Next slide, please.

Now, diving into today's webinar, Jessica Lee from CMS will first provide an overview of the CMS Quality Improvement Technical Assistance program. Then, I'll briefly provide some background on the Improving Asthma Control Affinity Group. The main event today are our two state spotlights. First, the California team will discuss their project to improve asthma control among Black and African American beneficiaries. Then, the Texas team will share their work improving asthma control for children. Following the state presentations, there will be opportunity for you to ask the teams questions. We'll end the webinar by sharing some upcoming quality improvement technical assistance opportunities. And with that, I'll hand it over to Jessica.

[Jessica Lee] Thank you so much, Natasha. Hello and welcome. I'm Jessica Lee, the medical officer in the Division of Quality and Health Outcomes in the Center for Medicaid and CHIP Services at CMS. Our division is home to our center’s Quality Improvement Program, which supports state Medicaid and CHIP programs, and our quality improvement (QI) partners, with resources tools and expert knowledge to improve care and outcomes for Medicaid and CHIP beneficiaries.

Affinity groups are a key element of our programming. The new groups are topic-specific action-oriented groups that help states build QI knowledge and skills, develop QI projects, and scale up, implement, and spread QI initiatives. These affinity groups are accompanied by webinars that include topical information and state QI success stories, like the ones you will here today.

I'm a practicing pulmonologist, and I so deeply appreciate the work that's been done to improve care and outcomes for people with asthma. We'd like to thank the eight states that participated in the Improving Asthma Control Affinity Group and, indeed, all of the states that have engaged in quality improvement activities with us. We have been so inspired by your commitment to improving care and enriched by the learning and projects you share with other states and with us. And with that, I will turn it over to Natasha.

[Natasha Reese-McLaughlin] Wonderful. Thanks, Jessica. So, of the affinity groups that Jessica mentioned, the first one was Improving Asthma Control. Asthma was one of the topics selected for the QI TA program because of its impact on Medicaid and CHIP populations and programs. Asthma places a large economic burden on the U.S., as well as in each state, with yearly medical costs associated with asthma surpassing $50 billion.

In addition to the large medical costs, there are also large social costs. Adults with asthma miss an average of five days of work each year, and it's the leading cause of school absenteeism. Additionally, the burden of asthma falls disproportionately on minority populations. Black children are twice as likely to be diagnosed with asthma than White or Hispanic children. As I said earlier, these financial and social costs place a burden on Medicaid and CHIP programs and populations.

Medicaid is the most common primary payer for asthma-related hospital and emergency department visits, and roughly 10% of Medicaid and CHIP beneficiaries have asthma. While there is no cure for asthma, it can be effectively managed to prevent exacerbations. For this reason, CMS saw improving asthma control as an opportunity for Medicaid and CHIP programs to improve quality and health outcomes and reduce cost. Next slide.

So, with that in mind, CMS launched the Asthma Affinity Group, with the overall goal of supporting teams to drive measurable improvement in asthma control. Asthma control includes clinical, environmental, and community-based strategies or interventions that help people with asthma achieve better health. To achieve improved asthma control, the affinity group sought to expand state Medicaid and CHIP staff knowledge of evidence-based asthma interventions; share state experiences and lessons learned from implementing asthma interventions; teach teams how to use data-driven approaches to test and evaluate an asthma project; support teams in working with quality improvement partners, including providers and communities; and improve the state's quality improvement skills by reviewing and using quality improvement science. Next slide, please.

The Asthma Control Affinity Group ran from April 2020 to June 2022 and had a total of eight state participants – Washington state, California, Colorado, Texas, Missouri, Louisiana, New Jersey, and Puerto Rico. As you probably noted, the affinity group coincided with the public health emergency. Despite the many challenges and competing priorities that came with the public health emergency, these state teams found ways to continue their QI work on asthma. Next slide, please.

Each state team had their own goals and tested different asthma ideas. This slide and the next share very brief descriptions of several years of hard work conducted by each of the teams. Instead of reading the descriptions today, I'll highlight some themes that emerged across the teams. Both our Puerto Rico and Louisiana teams worked with managed care organizations to increase home visits for children with uncontrolled asthma. The California and Washington teams both worked to address asthma disparities by working with providers. The California team, as you'll hear shortly, also conducted member outreach.

Moving to our last 4 teams, the Missouri and Texas teams focused on improving asthma management among children. Missouri fostered connections between managed care organizations and health homes. Meanwhile, the Texas team convened several managed care organizations and provided data support. Finally, the New Jersey and Colorado teams focused on reducing asthma-related hospital use by creating partnerships. The New Jersey team created partnerships between the state Medicaid agency and the Department of Public Health. And the Colorado Medicaid team partnered with their regional accountability entity.

With that, I'll turn the presentation over to our wonderful state teams. First, we'll hear from California. I'll turn the presentation over to Arlene Silva from California’s Medi-Cal agency to introduce her team.

[Arlene Silva] Thank you so much, Natasha. Hello everyone. My name is Arlene Silva, and I am a nurse consultant specialist with the California Department of Health Care Services (CHCS). I work on quality improvement and health equity under the Office of Quality and Population Health Management within our department. We recognize the significance of managing and controlling asthma exacerbations, and we strive to implement innovative approaches through our partnerships with our managed care plans and our community partners. As we strive to do more work on the asthma medication ratio (AMR) measure, California's performance on the CMS Core Set AMR measure was above the national median in measurement year 2020. In measurement year 2021 alone, 52%, that is 29 out of 56, of our plans surpassed NCQA’s 58th percentile benchmark.

CHCS is proud of the work of our plan partners, in particular, the work of Alameda Alliance for Health, whose AMR rate in measurement year 2021 was significantly better compared to their peers using California’s Medi-Cal managed care weighted average. Their work has been shared with other plans, or their managed care organization (MCO) peers, through California's quality improvement toolkit, which is a repository of resources and promising practices in California.

During this session, it is an honor to introduce our presenters, who will be discussing the importance of an integrated approach to member outreach among Black/African American Medi-Cal beneficiaries that Alameda Alliance has implemented through the CMS-led Affinity Group. Our first presenter is Dr. Helen Lee, who is the senior director of Pharmacy Services at Alameda Alliance for Health, with 21 years of pharmacy and healthcare-leadership experience in managed care. Dr. Lee is serving as PhD and a contract drug advisory committee member, and she's also a certified diversity executive.

Our next presenter is Dr. Rahel Negash. Rahel is a primary supervisor of Pharmacy Services at Alameda Alliance for Health. She started her career as an inpatient pharmacist and came to the Alliance as a transition of care pharmacist and case manager, and worked as a clinical and lead clinical pharmacist.

Last but not least is Rosa Reyes, a certified health education specialist who is a disease management health educator of quality improvement at Alameda Alliance for Health. So, without further ado, I'm passing it on to Dr. Lee.

[Helen Lee] Thank you, Arlene. So, we'll go to the next slide. And good afternoon and good morning everyone. Thanks for coming. Today, we'll be briefly talking about Alameda Alliance for Health, and the project outcomes. Alameda Alliance for Health is a Medi-Cal managed care health plan, and we are a public not-for-profit managed care plan. We serve over 320,000 children and adults in Alameda County since January of 1996. Our affinity group team was comprised of various different healthcare services and operation teams, such as Pharmacy Services, Quality Improvement, Health Programs, Complex Case Management, Analytics, Provider Relations, and, of course, senior leadership. Next slide.

So, you know, individuals with recent need for oral corticosteroids for asthma are at increased risk of COVID-19-related death, and, also, as Arlene shared, AMR is one of the key Healthcare Effectiveness Data and Information Set, known as the HEDIS, metrics. And so, the AMR, which is Asthma Medication Ratio, is defined as the percentage of beneficiaries identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 50% or greater during the measurement year. And the controller medications include inhaled corticosteroids or long-acting beta agonists. In an ideal world, the patient's asthma would be managed so that no rescue medication, such as Albuterol, would be needed. The ratio should be one-to-one; one controller medication by one unit of controller medication. Therefore, lower ratios indicate the patient was using more rescue medications. Next slide.

We try to put into one slide, what the issue is. The issue is, among Black adults ages 21 to 44, we identified health disparity for asthma control due to poor AMR. So, our goal was to improve asthma self-management for approximately 200 or more Black adults, such that, one, 63.6% or more of the target population have an AMR ratio of 50% or higher; and two, asthma-related emergency department visit decrease. Our strategy was to contact AMR groups, separated by score, conduct a survey, and make the proper interventions. Our interventions included coordinating primary care provider appointments, providing transportation and asthma education, mailing education materials, and offering a by-pharmacist consult.

Now I'm going to give this presentation to Rosa, and she will try to elaborate our outreach attempt for three groups. Go ahead.

[Rosa Reyes] Thank you, Helen. So, our outreach interventions took place between February 2021 and March of 2022, which are marked by a flag or triangle in the timeline at the bottom. The interventions were separated into three different groups based on AMR scores, and we followed QI’s best practice by starting with a small group of 12 members for our first group, and then increasing the number of members per group subsequently. Next slide, please.

The first outreach group happened in February 2021, where we outreached to 12 members with AMR rates between 0.40 and 0.49, and out of the 12 members, 6 members completed our survey and received at least one of our interventions, providing a total of nine interventions, which included transportation aid for two members, asthma education for four members, help with scheduling appointments for two members, and one pharmacist formulary assistance.

We then conducted a follow-up outreach call in September for the same 12 members. We were able to successfully reach two members, for whom we were able to provide at least one intervention. Both members received asthma education and a pharmacist consult, and one member received a case management referral. Next slide, please. And I'll pass it on to Rahel.

[Rahel Negash] Thank you, Rosa. So here on this slide, we're looking at the monthly AMR-by-member results for group one outreach calls. So, first, we can take a look at the AMR goal line marked in red to see those that had improved scores or decreased scores from that 0.5 goal. We can see that three out of six members had AMR compliance after our outreach. That's marked with the first arrow at the bottom of the graph, indicating outreach call intervention.

So, I can also take a look at each of the members to demonstrate and give more information on what happened for those who fell below the line. So, first, we can start with member four, that's in light green. So, here, we see a sharp drop off in their AMR score in September. When we looked at our records, we noted that the sudden decline was because the member was no longer enrolled with the plan. So, this would explain the sharp decline.

Next, looking at member five, in black, we see a decrease in AMR score after our intervention. And when we took a look at our records, we noticed that the member was actually filling a non-National Committee of Quality Assurance (NCQA)-approved control inhaler after our intervention. So, as a note here, our reports only capture NCQA-approved control inhalers. Therefore, the member's AMR in this case was actually compliant.

If we look at member three, marked in light blue, we do see a decline in AMR score after our call. When we looked at our records, we saw that this member was also filling on non-NCQA-approved control inhaler; therefore, their AMR score was also compliant. And then, lastly, if we look at member one, in orange, we do see a decline in their AMR. Our records showed that this member fell out of eligibility because they switched to our group care line of business, so the data here doesn't reflect all of the medications used.

So, after individual member review, we concluded that at least five out of six of these members actually had AMR-compliant rates after our intervention. Next slide.

Here, we're looking at the monthly asthma-related Emergency Department (ER) visits for outreach group one in 2021. Here, we're pointing out that our outreach calls were made in February, so we see that arrow pointing down to indicate when we called. And we're noting here that there were two ER visits in July and November – this was for two different members. All of the other members had no asthma-related ER visit. Next slide. I'll hand it over to Rosa.

[Rosa Reyes] So, then in February 2021, we launched our second outreach group of 15 members with AMR scores between 0.3 and 0.39. We were able to reach 5 of the 15 members and provided at least one intervention per member, with a total of seven interventions. Three members received transportation assistance, two members were provided with asthma education, one member received a pharmacy consult, and, lastly, one member was referred to Beacon, our behavioral health service. Next slide please.

[Rahel Negash] Here, I'll highlight more about the data. So, we're looking at the monthly AMR by member for outreach group two, from 2021 to 2022. So, here, we're seeing a positive shift after our September to October outreach calls, so that's shown with the arrow pointing up. And here, we're showing that four out of five members had AMR improvement after our intervention. Three out of five reached AMR compliance by January 2022. Next slide.

Here, we're taking a look at the monthly asthma-related ER visits for outreach group two in 2021. I'll note that all of the activity prior to our outreach call related to 11 asthma-related ER visits, and this is all for

one member, and prior to our calls. After our call, there was no ER asthma-related visits in 2021. Next slide.

[Rosa Reyes] Lastly, our third outreach group took place from January to March of 2022. We reached out to 35 members with the lowest AMR scores of 0.2 to 0.29, and we were able to reach 12 members, of which 7 agreed to complete our survey. All seven members received at least one intervention, with a total of 14 interventions. So, five members received transportation assistance, five members were provided with asthma education, three members were offered smoking cessation support, and one member was referred to Beacon, our behavioral health service. Unfortunately, our data is currently pending for this group, so we won't be able to share it with you all today. But we have overall AMR results and ER results. Next slide, please.

[Rahel Negash] Here, we're taking a look at the AMR compliance rate for all groups, so this ranges from 2019 to January 2022. Here, we're highlighting our group one and group two outreach calls in February and between September and October. We'll also note that the data here shows an increase in AMR compliance rate after our first and second outreach call intervention; that is approaching that 63.6% goal line at the top that's marked in turquoise. Next slide.

Here, we're showing our asthma-related ER visits for all groups, so this ranges from 2019 to 2021. And as we can see, the data doesn't seem to reveal much change as it relates to the ER visits over this three-year timespan. Next slide.

Here, we're looking at lessons learned. So, first, we noticed that this project had a lot of interest and openness as it relates to the asthma survey, and we also had a lot of intervention. So, all of the live calls in group one and group two agreed to the survey. So, when we were able to reach members, they were receptive to continue conversation about their asthma. In group three, we had 58% of the live calls agreeing to the survey. So, overall, it was a total of about 78% who were completing the survey and receiving assistance.

We also learned that the essential teams for this project varied over the course of the project length, and it included Pharmacy Services, Quality Improvement, Health Programs, and Complex Case Management. We also noticed that getting access to active member phone numbers was a significant barrier, and a lot of time was spent trying to acquire the appropriate numbers to call.

Lastly, we learned that potential data skewing should be considered when interpreting AMR scores. So, as we mentioned before, an example would be the inaccurately low AMR scores due to limited NCQA-approved medication. So, for instance, we had members who were filling, as an example, generic Advair Diskus every month, but their AMR score was below 0.5. Also, some members lost appropriate enrollment, and so they were no longer eligible for the project, and their scores were no longer reflecting their medications that were being used. Next slide.

[Rosa Reyes] So, during the course of our project, the Affinity Group provided a lot of support during group meetings, where they helped us organize and summarize appropriate data, goals, and interventions. For example, they encouraged us to use a plan-do-study-action (PDSA) and think about study design. They provided resources and tools to help catalyze our project movement and understanding with internal departments. And the TA teams included subject matter experts who helped validate appropriate project approach during our one-on-one state calls. So, we are appreciative of their support and knowledge throughout the process of this project. Next slide, please.

In regards to next steps, we are looking to increase provider involvement to optimize improved outcomes. Some of the interventions that we are looking at are a collaboration with the California Department of Public Health to create videos for providers and to deliver provider education through fax blasts. We would also like to increase QI department-driven asthma initiatives for continued Medi-Cal Accountability Set, or MCAS, measures for healthcare delivery systems, which include AMR HEDIS measure projects. And currently, our MCAS AMR HEDIS measure is above the benchmark, so we would like to continue this trajectory. This will conclude the end of our presentation. Thank you for your time today.

[Natasha Reese-McLaughlin] Thank you so much to the California team for that wonderful presentation. I'm now going to turn the presentation over to Susana Peñate, who will share highlights from Texas' Affinity Group project.

[Susana Peñate] Okay. Hello. Good afternoon all. I am Susana Peñate from the Texas Health and Human Services Commission (HHSC) in the Medicaid and CHIP Services Division. For this project, I serve as a project coordinator for the Texas Asthma Control Project for STAR children in the Nueces and Harris service areas. Texas decided to apply and join the Asthma Affinity Group because, first, it supported our Texas HHSC business plan, which included a specific goal to improve health outcomes for children with chronic asthma.

And then, additionally, our sister state public health agency, the Department of State Health Services, at the time, had data that showed that Medicaid paid for over 60% of total asthma-related emergency department (ED) visits for children in our state. And then, lastly, our Medicaid and CHIP asthma-related quality measures, like the Asthma Medication Ratio, our asthma-related Potentially Preventable Admissions, PPAs, did show a need for improvement among our Medicaid and CHIP managed care programs. So, it's just a great opportunity for Texas to join the Affinity Group and learn from the other states. I'm really excited to share how Texas approached this project and so we can go on to the next slide.

Okay, first, I would like to share who was included in the Texas core team. It was the Texas Health and Human Services Commission (HHSC) in the Medicaid and CHIP Services Division that led this initiative for Team Texas. From our Medicaid area, we were joined by one of our Associate Medical Directors who has experience in family medicine, and then folks from our Medicaid Quality Team. Our core team also included our public health state agency, the Department of State Health Services, including their team from the Texas Asthma Control Program. So that agency has a statewide asthma collaborative, so they had a wealth of resources and connections that we really used for this project. And then our core team also consisted of Medicaid managed care organization (MCO) partners. Next slide.

On this slide, I'd like to share the Texas Aim statement. I won't read through the Aim statement itself. I will discuss our selected population and sort of why we chose this group and these areas, and then discuss our outcome goals.

Our selected population was children in STAR who resided in the Nueces and Harris service areas. STAR is one of our Medicaid managed care programs, but most of our children's Medicaid beneficiaries receive services through STAR, so that's why we chose that managed care program. And then we focused on these two parts of Texas. There's a map there on your screen, Harris and Nueces on the south and southeast side of Texas. We chose these two service areas because, one, Nueces, at the time, had the lowest Asthma Medication Ratio compared to all of our other service areas.

And then Harris was selected, because our Medicaid agency had existing partnerships with MCOs who were interested in asthma control improvement. So those are sort of the reasons why we focused on those two areas. And our outcome goal was to reduce asthma-related Potentially Preventable Admissions or PPAs, and Potentially Preventable Emergency visits, or PPVs, by 20 percent. And then to also improve the Asthma Medication Ratio to 75%. Just keeping in mind that our baseline data was 2019 data. Next slide.

And in Texas, we, did have certain drivers that initially helped the team to tailor our interventions. These drivers include making sure we had interventions that were geared up, providing clinically appropriate care, providing non-clinic care appropriate to the level of asthma severity, and improving care coordination for members with asthma. And then here on the right part of your screen is the measures box. Some of the measures we were interested in tracking were the Asthma Medication Ratio, like California, asthma-related emergency department visits, inpatient admissions, and then several other measures related to asthma-related specialist visits. Next slide.

For this Affinity Group, Texas developed our own model, which we've applied to other affinity groups we've participated in. But in this model, the Texas Medicaid and CHIP agency received technical assistance and resources and knowledge from CMS and Mathematica. This includes tools to organize a QI project and QI best practices, including insights on lessons learned and barriers faced by other participating states. HHSC took in this technical assistance and then convened a core team that consisted of other state agency staff and MCO staff. And in this forum, the state agency provided project direction and guidance and then really encouraged the core team to share learning with one another and project updates. And it was actually then the MCOs who, based on the learnings from the core team, implemented their own and very, very different QI asthma projects. So, this is, in summary, what the Texas model looks like, and it has worked really well for our Medicaid agency and for other affinity groups. Next slide.

And so now to go into more detail on the Asthma Affinity Group. In Year One, we really focused on establishing relationships with our external partners – that includes our MCOs – and really delved into learning what the asthma landscape looked like across the state. And just to note, Year One was from June 2020 through June 2021.

So, initially, HHSC sent a survey to all of our Medicaid and CHIP MCOs to learn about their disease management programs and their asthma-related projects and interventions. Some of the survey questions that were included were what asthma self-management initiatives does your disease management program provide, what is your definition for a member with asthma, how can an MCO's provider network use this data, and if that's an option that's available, and then a description of the MCO's asthma education programs, any home environmental service referrals they provide their members, and then any sort of really case management or value-added services.

So, some key takeaways from the survey was that MCOs were doing several asthma-related initiatives for their Medicaid and CHIP members. Another really interesting thing we learned was that our MCOs – keep in mind, we have 17 MCOs in Texas – so the MCOs had varied definitions for quote members with asthma. So, after receiving the responses for the survey, HHSC recruited six MCOs to participate in the Asthma Affinity Group. The way we selected the MCOs was, one, we selected the MCOs in Nueces who had an Asthma Medication Ratio below the 25th and 50th national percentile in that service area, and then for some of our MCOs, sort of what I mentioned earlier, our Medicaid agency had existing relationships with the Associate Medical Directors with that MCO, who were actually pediatric pulmonologist and had a really great passion for asthma control improvement. So, we thought that'd be great champions for this project.

And so, after selecting six MCOs, Team Texas, we convened the two workgroup series. Workgroup One focused on creating standard definitions for members with asthma and delved deeper into risk stratification. And then Workgroup Two focused on assessing existing asthma programs in those two specific service areas and then learning about different asthma education materials that some of our community-based organizations use. And I can share, briefly, who participated in each workgroup.

So, Workgroup One, with help from our sister public health agency, DSHS. We convened several providers from across the state to provide the expertise needed for Workgroup one. And then Workgroup Two, we reached out to local health departments who had asthma programs and community health centers who served those two service areas to provide more specific insight. Next slide.

Okay. In Year One, after that sort of baseline work to understand the asthma landscape, the MCOs selected their QI project ideas. And their ideas varied. Most of the MCOs selected a different project idea. Some MCOs chose to pursue a texting campaign, a referral system to asthma-related resources, like home environmental services and home weatherization services. Some MCOs chose to enhance existing case management programs for the members with asthma by developing new assessments for those members. And then based on the work from Workgroup One about learning more about the definition for members of asthma, some MCOs went ahead and updated their asthma registry using that new definition.

But in year one, the agency, HHSC, we also published guidance on how asthma education was covered by our Medicaid and CHIP programs. So that was sort of something that happened tangentially to this QI-focused work. And then in Year One, HHSC also created a data dashboard for asthma-related utilization data, which you will see on the next two slides. Next slide.

Okay. So, in this slide, HHSC developed a Tableau dashboard, specifically for these two service areas, and for the six MCOs. The data dashboards can be filtered by age group, race, ethnicity, and sex. This particular one tracks asthma-related ER visits and inpatient hospitalization data. We started off with 2019 data as our baseline. And then, currently, we have 2020 and 2021 data. You'll see that in 2020 – again, in hindsight, this Affinity Group started right in the middle of 2020 – there is a very noticeable dip in our asthma ER visits per 1,000 members rate, and, also, our asthma-related inpatient admissions per 1,000 members rate. So, next slide.

And then one of the other pages in our dashboard focused on specialists, like member utilization of certified respiratory care practitioners, allergists, and pulmonologists. We saw similar trends for this data too, than the previous slide, in terms of a slight dip in 2020. In this dashboard, we could also filter by the same variables as the previous slide. Next slide.

Okay. And in Texas the MCOs actually began implementing QI projects in Year Two, but by that point, I think we had a very solid foundation of QI and PDSA cycles. So, the MCOs, they implemented their QI projects in June of 2021. They submitted plan, do, act, study (PDSA) cycles to HHSC for review. Each did develop run charts for the first six months of their pilot projects. And towards the end of Year Two, some MCOs did extend their QI projects to other areas and populations.

And so, during Year Two, how HHSC supported each MCO was by providing the PDSA cycle worksheet, the run chart maker templates, and then we also shared the specifications that we use for the HHSC Tableau data dashboard and then also resources on how to expand their QI projects. And, again, this is with support from CMS and Mathematica, who provided a lot of resources, or most of these resources. Next slide.

And as far as lessons learned, the first one is that having a consistent definition for members with asthma with such a large number of MCOs, again, it was a surprising find from that survey and ultimately, Workgroup One took a little bit longer than expected to create a consistent definition. But, ultimately, valuable time well spent, because it was a foundation for the development of the data dashboard.

The second is that, starting with a small number of members, as recommended by the QI method we were using, this required coaching to the MCOs, because MCOs are definitely more accustomed to operating projects at a larger scale. This is something that Team Texas, with our other affinity groups, have really tried to fine-tune with coaching MCOs to focus on a smaller number of members with each PDSA cycle.

The next lesson learned is that small-scale interventions will not always result in an immediate improvement for the AMR, for the selected population in the service area, and, really, to be flexible and open to pivoting, especially when there were staff changes. What helped Team Texas and the MCO partners was having a consistent champion who was the main point of contact with the state. Next slide.

Okay. Reflections on the Affinity Group. The first one is at the all-state workshops were really helpful to Team Texas because we could see other barriers and successes of other state participants. Also, the addition of a second year to the Affinity Group provided long-term support because, as you saw, the MCOs did not start implementing until towards the end of Year One. So, having that Year Two was critical for Team Texas. And then, as part of participating in this affinity group, both state and MCO staff were offered access to quality improvement courses to learn about QI methods. So that really helped staff who might not be as familiar with QI. But overall, participating in this Affinity Group helped HHSC strengthen relationships with MCOs and community stakeholders, and then also develop some policy guidance related to asthma.

And then next steps for Team Texas is to continue to monitor our asthma-related data, and add our 2022 data to the Tableau dashboard; continue to participate in other forums with asthma stakeholders across Texas; and, as I mentioned, apply and improve upon our Texas model for other affinity groups that we participate in. Thank you.

[Natasha Reese-McLaughlin] Wonderful. Thank you so much, Susana. I'm going to open the floor up for questions and discussions, so, again, please chat your questions into the chat box. We did receive our first question, and it's for both teams. But given successes of your Affinity Group project, does your state have plans to spread the interventions to other plans, populations, and geographic areas? Would one of the teams like to start?

[Susana Peñate] This is Susana. I can provide the first response. So, several of the MCOs for our core team did end up expanding their projects to either one of their other service areas, or maybe to another population. So, yes. And then HHSC, we continue to participate in statewide asthma forums and try to share information about the incredible work that the MCOs did in those forums as well.

[Helen Lee] Yeah. And also, for California, we had a chance to present this information at DHCS Global Drug Utilization review board, and several plans did express interest. So, we've been sharing our information, the collateral, and also DHCS did actually incorporate our information as a part of the toolkits for providers.

[Natasha Reese-McLaughlin] Wonderful. Thank you for that. Our second question is for the California team: reaching out to members was challenging, but you did very well overall. Do you have any other ideas about how to reach more folks going forward?

[Rahel Negash] That's a great question. It definitely takes, you know, time to call and have the appropriate numbers. We would like to expand. I think that, at this point, it does seem like it just is something that may require consistent outreach from maybe a group of people, or at least two or three. With our groups, it ranged. The first group had at two outreaches initially, and one pharmacist. The second group had one individual, and the third had one. So, it could be, in order to expand, reasonable to include maybe a larger outreach group of individuals. So, yes, expanding would be good.

[Natasha Reese-McLaughlin] All right, thank you for that, Rahel. I just want to correct myself. I earlier said to please put questions into the chat, but actually there should be a Q&A feature on your screen. If you don't see it, there are three dots next to the chat feature, and that should open up to a Q&A function. So, please submit questions there.

But we have our third question, which is for Team Texas. Susana, could you say more about how you coached your managed care organizations, what kind of questions were asked and how they were addressed?

[Susana Peñate] Yeah. So initially, I can share more about how we've made improvements on how we coach our MCOs with the other two affinity groups we've participated since this one. So, we initially started with assessing and talking with them MCOs about, one, their data capabilities and any barriers they have with tracking data. And then we also asked an interesting question at the beginning – what do you wish you could track? So that's sort of the first step. We introduced the QI concepts that we learned from CMS and Mathematica, like the different types of measures, what a run chart is, and what a PDSA cycle method is. So, we teach the MCOs those foundations in the first couple of months. And then afterwards, the MCOs, they have the flexibility to choose their own project, their own intervention.

And then the state agency, we review each month with the MCOs, their PDSA cycle worksheet. MCOs can ask any questions. They'll let us know of any barriers or successes and lessons learned with each PDSA cycle worksheet. And then for any questions that the agency might get stuck on or need a little bit more help on, that's when we like to go to CMS and Mathematica for their technical assistance and

expertise. So, we've definitely fine-tuned how we coach MCOs throughout the years. So, so far, we've seen it's a strategy that works for Texas.

[Natasha Reese-McLaughlin] Great. Quick follow up was, how frequently did you meet with your MCOs, and did you meet with them all together or separately?

[Susana Peñate] So, for this Asthma Affinity Group, it was definitely sort of the – I see it as the guinea pig of how we coached MCOs. So, for Asthma Affinity Group , we met all together, all the MCOs together once a month for Year One. And then for Year Two, we met every other month. But for the other two affinity groups, after this Asthma Affinity Group, we fine-tuned that and found it more successful to meet individually with each MCO on a monthly basis to get that one-on-one coaching that they might need.

[Natasha Reese-McLaughlin] Thank you so much for that, Susana. We have another question that came in for California regarding the HEDIS measure. Could you say a little bit more about the medications that were not included in it, and if you have plans to use a different measure, moving forward.

[Rahel Negash] I can address the question. I think the question is relating to the NCQA-approved list. So, we did see that there were some medications that were not captured with our data. So, you know, it's just, on our end, we just have to be aware of the NCQA-approved list of medications, and as new medications enter the market, like the generic Advair Diskus, you know, we just have to take into account that the NCQA-approved list may not be at the same speed as the market. So, at this time, it's just something that we're looking out for. But, yes, it is something that we'd want to update in our search engines as well.

[Natasha Reese-McLaughlin] Wonderful. I just want to remind the attendees that we will be making these slides available after this presentation. I'm seeing that we are running out of time for questions. Next slide, please.

First, a huge thank you to our state presenters for sharing their stories and lessons learned. And a thank you to all of our eight teams for their work to improve asthma outcomes for their beneficiaries in their state. Before closing today, I want to share some upcoming quality improvement TA resources. First is the Medicaid and CHIP Quality Improvement Open School. Susana from Texas spoke a little bit about this resource during her presentation today.

Open School curriculum is designed to support Medicaid and CHIP staff develop, strengthen, and use QI skills. Participants have access to courses on how to conduct quality improvement projects. They also have access to the Institute for Healthcare Improvement's extensive resource library. If you're interested in participating, please fill out an expression of interest form at the link shown on the right side of the screen, www.ihi.org/macquality. Next slide, please.

CMS also offers quality improvement office hours. These office hours are an opportunity for state Medicaid and CHIP teams to ask their quality improvement-related questions to experts. Office hours are held weekly. Three times a month, they're hosted by a quality improvement advisor. Once a month, they're hosted by a CMS representative from the Division of Quality and Health Outcomes. There's no need to sign up in advance. To join the office hours distribution list, please email the mailbox shown on the screen macqualityimprovement@Mathematica-mpr.com. Next slide.

Finally, CMS offers a variety of on-demand quality improvement technical assistance. These resources are available on Medicaid.gov, and include videos on how to get started on quality improvement, driver diagrams with evidence and experience-based quality improvement ideas, measurement strategies for quality improvement projects, and highlights from CMS's Affinity Group projects. CMS also offers one-on-one QI TA support via their mailbox, shown here on the screen, MedicaidCHIPQI@cms.hhs.gov.

The on-demand QI TA resources I just mentioned focus on specific priority populations. We're happy to announce that the asthma QI TA resources are already available on Medicaid.gov. Resources for tobacco, oral health, and postpartum care will become available later this spring. A bit after that,

resources related to foster-care populations and follow-up care for behavioral health will become available this summer. Finally, at the end of this year, CMS will release materials related to managed care quality improvement and well-child visits.

Again, if you have any questions, please contact the CMS Quality Improvement Team at MedicaidCHIPQI@cms.hhs.gov.

Thank you all for coming today, and thanks again to our state speakers. If you can, we'd appreciate if you complete the webinar survey as you exit. Have a great rest of your day.