CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits, 0-15 months

Thursday, February 8, 2024, 4:00 – 5:00 PM ET

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Technical Instructions

Welcome to the CMS State Spotlights in Improving Infant Well-Child Visits Webinar!

- All participants are muted upon entry
- Close captioning and WebEx assistance can be accessed at the lower left of the window

- There will be a Q&A session at the end of the webinar
  - Please submit questions using the Q&A panel throughout the presentation

- Please contact Derek Mitchell (Event Producer) through the Q&A panel with any technical issues you may encounter
- There will be a **survey pop-up** at the end of the webinar
  - Please complete this survey before leaving the meeting
- A **recording of the meeting and slides** will be available after the webinar on Medicaid.gov.
  - We will send an email when these materials are posted

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Agenda

- CMS Introduction
- Improving Infant Well-Child Visits, 0-15 months Affinity Group
- State Spotlights
  - South Dakota
  - California
- Questions & Discussion
- CMS Quality Improvement Technical Assistance (QI TA) Opportunities

CMS Introduction

Kristen Zycherman, Centers for Medicare and Medicaid Services

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CMCS Quality Improvement Technical Assistance Program

- The Center for Medicaid and CHIP Services (CMCS) QI TA program supports state Medicaid and Children's Health Insurance Program (CHIP) programs and their QI partners with information, tools, and expert knowledge to improve care and outcomes for Medicaid and CHIP beneficiaries
- As part of the QI TA program, CMCS convenes action-oriented affinity groups (AG) to help states build QI knowledge and skills; develop QI projects; and scale up, implement, and spread QI initiatives
- Each AG is preceded by a webinar series that includes topical information and state QI success stories

Maternal and Infant Health Initiative

- **The Centers for Medicare & Medicaid Services (CMS) launched the Maternal and Infant Health Initiative (MIHI) in July 2014**
- **The MIHI was built on recommendations from CMS's Expert Panel on Improving Maternal and Infant Health Outcomes in Medicaid and Children's Health Insurance Program (CHIP) and focused on improving the rate and quality of postpartum visits and increasing the use of effective methods of contraception**
- **In 2019 CMS convened a MIH expert workgroup to identify and prioritize recommendations in three areas where Medicaid and CHIP have a significant opportunity to influence change**
  - Decrease the rate of cesarean births in low-risk pregnancies
  - Increase the use and quality of postpartum care visits
  - Increase the use and quality of well-child visits for infants 0 to 15 months

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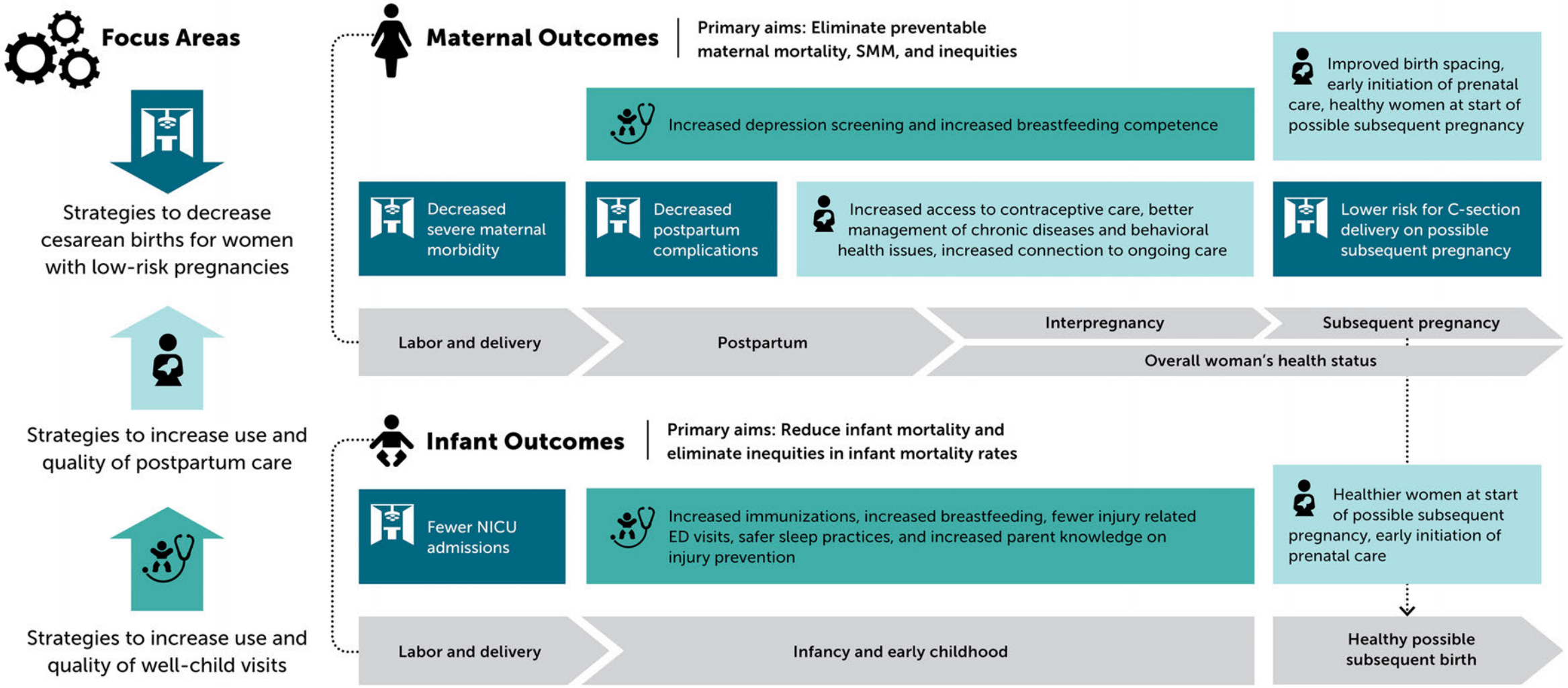
Focus Areas to Improve Maternal and Infant Health Quality



C-section = cesarean section; ED = emergency department; NICU = neonatal intensive care unit; SMM = severe maternal morbidity

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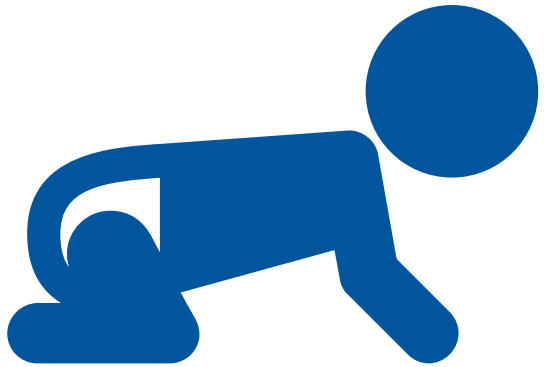
Why Focus on Infant Well-Child Care?



- **Well-child visits…**
  - Improve children's health
  - Support caregiver behavior to promote health and prevent injury and harm
- **Provide essential health services for infants**
  - History and physical examination
  - Immunizations
  - Vision and hearing screening
  - Developmental and behavioral assessment
  - Oral health risk assessment
  - Social assessment
  - Care coordination
- **Provide essential health services for caregivers**
  - Caregiver education
  - Maternal depression screening

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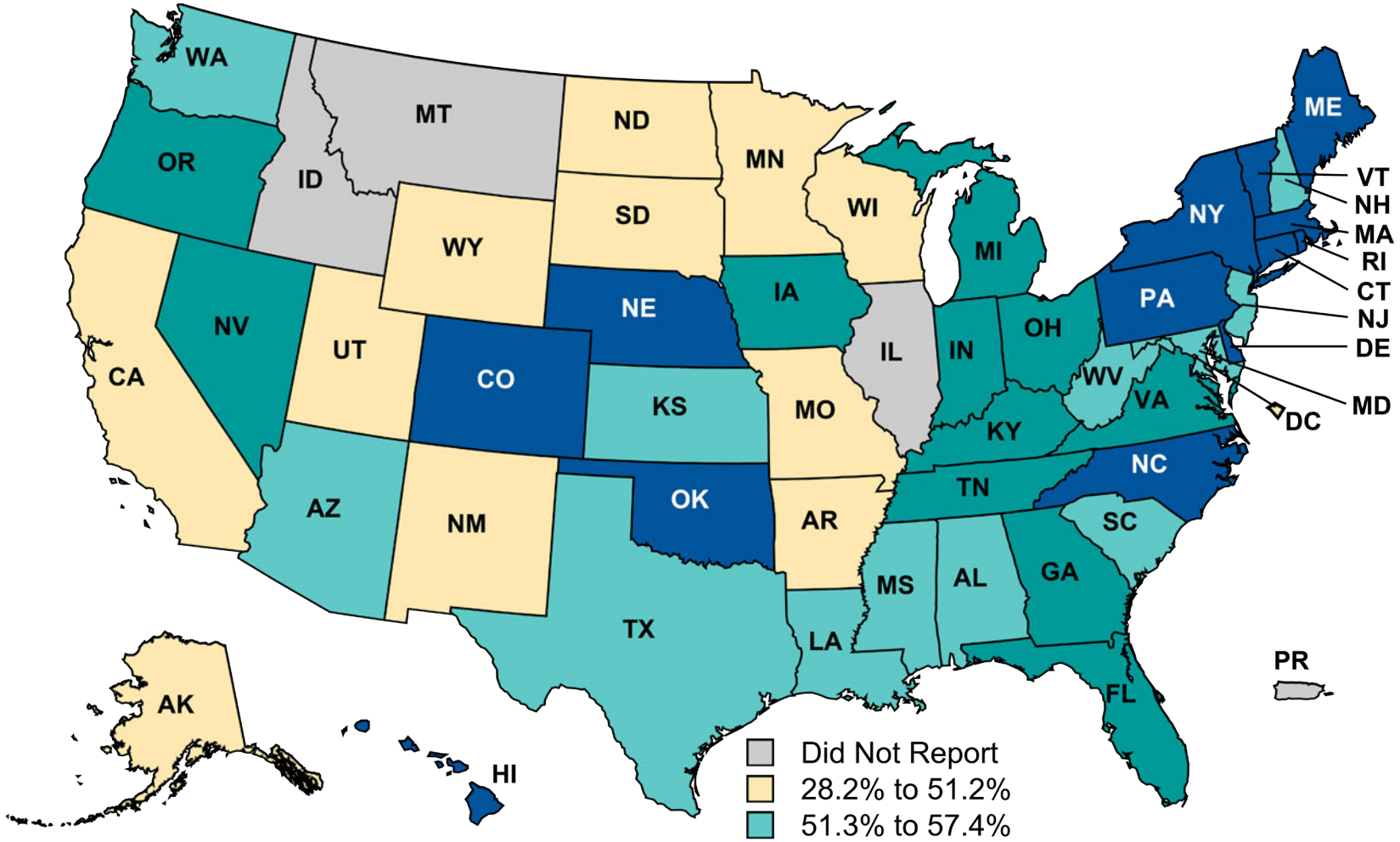
Geographic Variation in the Percentage of Children Enrolled in Medicaid or CHIP Receiving 6 or More Well-Child Visits in the First 15 Months of Life (W30-CH), FFY 2022 (n = 48 states)



State Median: 57.5%

Source: Mathematica analysis of the QMR system reports for the FFY 2022 reporting cycle as of June 1, 2023.
Note: When a state reported separate rates for its Medicaid and CHIP populations, the quartiles were calculated using the rate for the program with the larger measure-eligible population.

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Improving Infant Well-Child Visits Affinity Group

Olivia Chan, Mathematica

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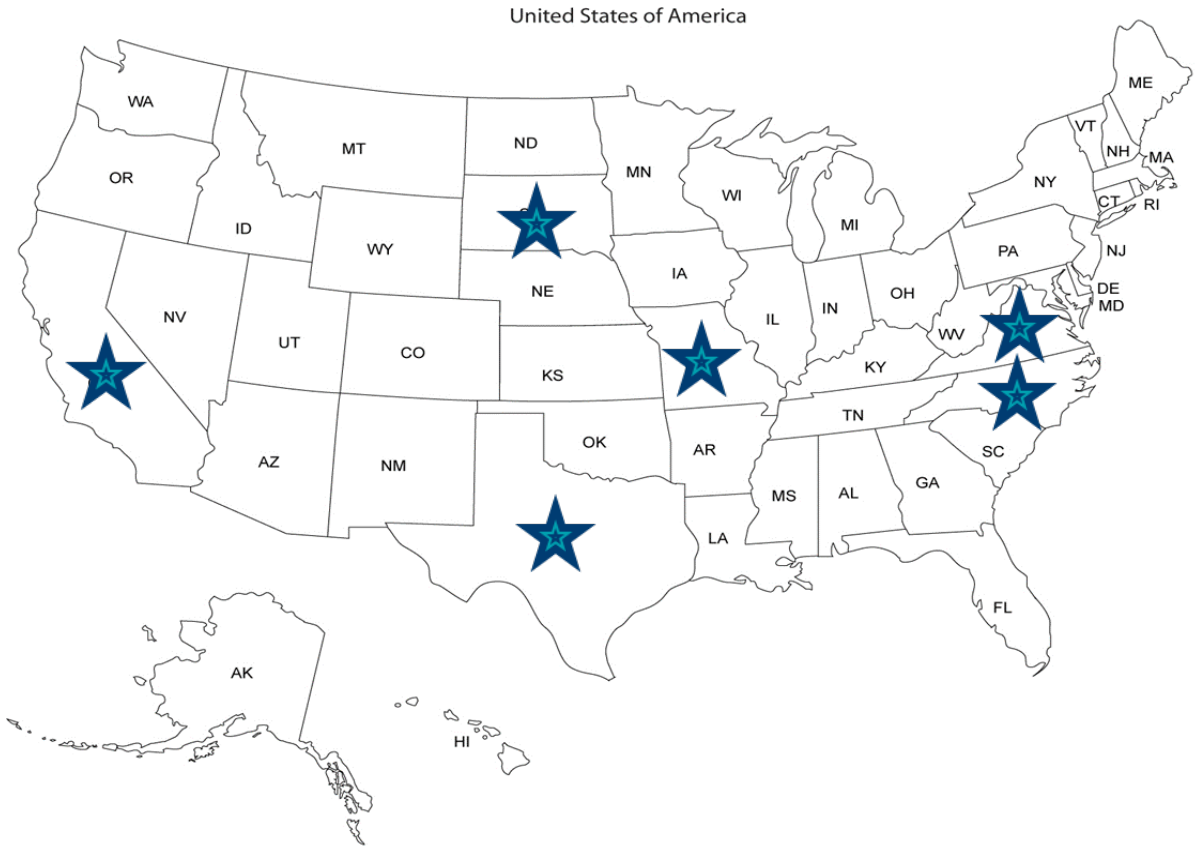
Improving Infant Well-Child Visits Affinity Group Overview

- **December 2021 – December 2023**
- 6 participating states
  - California
  - Missouri
  - North Carolina
  - South Dakota
  - Texas
  - Virginia
- Action-oriented affinity group that supported Medicaid and CHIP programs and their partners in the design and implementation of data-driven quality improvement projects



Affinity Group State Highlights

California

Sought to improve infant well-child visits in the first 6 months, where most visit gaps exist, and impact 6 or more visits in 15 months

Engaged three managed care plans that conducted individual improvement projects exploring enrollment improvements; prenatal, hospital, and postpartum member engagement using outreach checklists and member assistance; reminder/recall outreach; self-care member incentives; and barrier reduction

Missouri

Sought to increase the rate of infant well-child visits by 2%, focusing on specific geographic populations chosen by managed care and provider partners

Engaged three managed care plans to test enrollment and use of electronic health record patient portals, desk references supporting IWC visit scheduling, and a member incentive program to encourage greater visit attendance

North Carolina

Aimed to increase the rate of infant well-child visits for ages 0-15 months by 5%, from 62.3% to 67.3%, and aligning infant well-child QI work with state's newly implemented managed care program

Implemented a learning collaborative with five managed care plans and integrated the new statewide quality strategy into the infant well-child quality improvement work

Affinity Group State Highlights (continued)

South Dakota

Sought to increase the rate of infant well-child visits among American Indian/Alaska Native population by 10% through strong partnerships

Tested a social media campaign with culturally-specific messaging, rack cards explaining the importance of well-child visits, provider communications on billing for well-child visits concurrent with acute care visits, and cash card incentives to address transportation or other barriers

Texas

Sought to reduce disparities in infant well-child visit rates and increase the number of completed check-ups through a Texas-led learning collaborative

Brought together 10 managed care plans that each tailored the state's aim statement, chose an infant population of interest, and tested interventions that included scheduling assistance, tiered and/or electronic reminder/recall outreach, and member incentives

Virginia

Sought to improve infant well-child visit attendance in Northern Winchester, Richmond, Southwest, Tidewater, and Petersburg regions by increasing rates of attendance for the first well-child visit

Worked with four managed care plans to assist families with Medicaid enrollment, schedule appointments through outreach calls and direct scheduling software, address barriers, and enhanced case management and care coordination

South Dakota Department of Social Services

Division of Medical Services

Ashley Lauing, Policy Strategy Manager

Samantha Moon, Senior Data Analyst

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Background: South Dakota

- Fee-For-Service
- In State Fiscal Year 2023
  - 1 in 6 South Dakotans are on Medicaid or CHIP
  - 23% of children born in SD are born on Medicaid or CHIP
  - 40% of children born in SD will be on CHIP or Medicaid within the first year of life
  - 2 in every 5 children under the age of 19 in South Dakota has coverage through Medicaid or CHIP
- Until Medicaid expansion in July 2023, 68% of recipients in South Dakota were children

AG Project Aim Statement

The Challenge	Less than 50% of recipients under age 15 months receive the recommended 6 visits (W30-CH HEDIS measure) on average. The W30-CH median decreasing across all states, indicating that this is not a unique problem to SD. Rates for American Indian/Alaska Native (AI/AN) in SD are almost less than half of that for the remaining population.
Our Aim	Increase the percentage of AI/AN recipients meeting W30-CH by 10 percentage points to 30.6%. This would also increase the overall state rate as the AI/AN population accounts for 36% of the South Dakota Medicaid population.
Strategy	A multi-faceted approach to trying different strategies.

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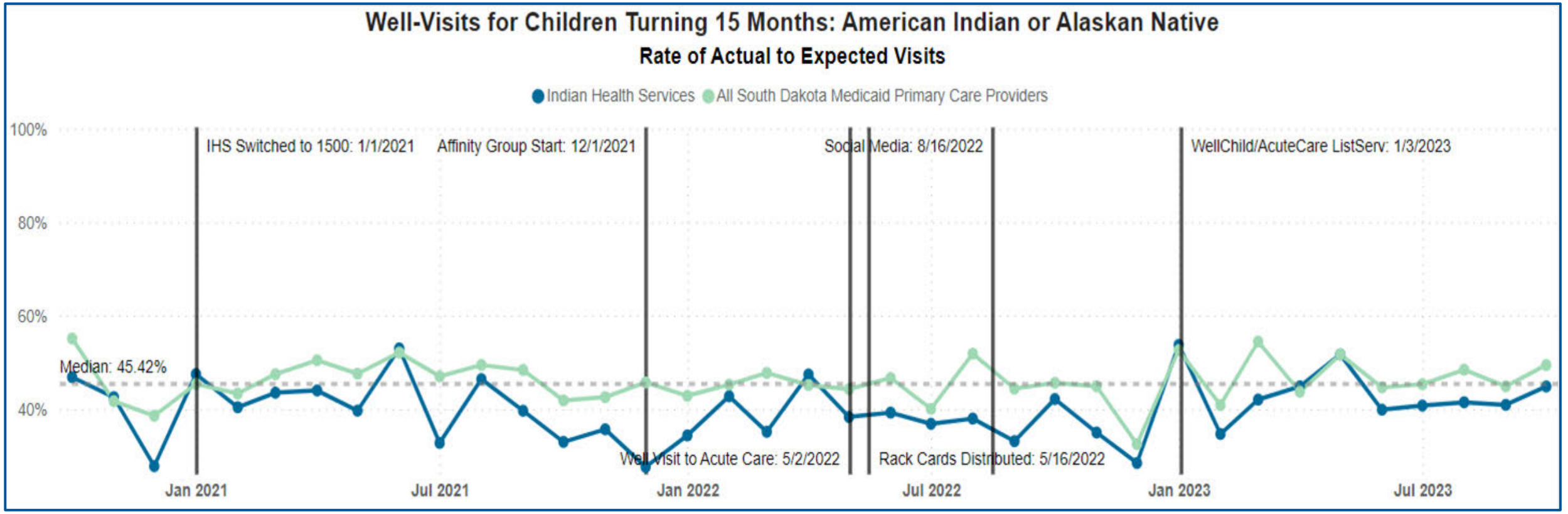
Strategies and Interventions

- Move from UB04 to HCFA1500 (billing form change) as an attempt to better capture well-child visit attendance
- Rack cards
  - Easiest initiative to track outcomes and results and for provider participation
- Social media
  - Culturally tailored messaging; good qualitative response; hard to track quantitative impacts
- Acute care visit transitioned to wellness visits when appropriate
  - Qualitatively most providers currently do this; no quantitative feedback
- Immunization only visits transitioned to well-child visits
  - Easy to count number of transitions, most parents don't appreciate the difference
- Days set aside for well-child visits
  - IHS currently uses this strategy and pairs attendance with incentives
- Well-child visit fairs
- Incentive cards
  - PDSA tested fuel cards; providers found that other incentives work better (for example, diapers, formula)
- Listserv messaging
  - Communication changes and impacts with providers

Measures and Data

- **Goal: track effectiveness of PDSA's**
  - Attempt #1: calculate HEDIS measure as-is
    - Specifications intended for yearly calculation; not real-time
  - Attempt #2: track overall number of wellness visits each month
    - Not normalized across months; misleading
  - Attempt #3: compare actual number of visits with expected number of visits each month
    - Measure: actual/expected
    - "Expected" based on periodicity schedule, children should have wellness visits at 0, 1, 2, 4, 6, 9, 12, and 15 months
    - Example: 1,071 visits expected for a particular month based on AI/AN recipient age and eligibility in the Primary Care Provider program; 442 occurred = 442/1,071 = 41.27%
    - Limitations
      - Could be considered too restrictive
      - Claims lag

Measures and Data



Note:
- System Rate, in this case, is for Indian Health Service
- All Systems Rate is for the state as a whole

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Spread and Sustainability

- One provider continues to work with a foundation on other initiatives
  - Looking to use incentives such as formula and diapers during well-child visits
  - Stemmed from our transportation card idea
- Another continues to outreach and try to bring recipients in
  - Focusing on monthly well-child days with incentives and flexible provider schedules
- Pregnancy program requirements
  - Using the PDSA process learn about “barriers to care initiative” requirements
  - Requiring maternal health providers to help parents select the provider for a newborn and coordinate care
- Continued communication efforts
  - Provider listservs with recommendations and ideas.
  - New blog with monthly updates from Medicaid Chief Medical Officer

Challenges

- Claims run-off
  - Most accurate data is 6 months old
  - Hard to track immediate results
- Competing priorities
  - Implemented multiple initiatives within the same timeframe
- Buy-in for certain change initiatives

Lessons Learned and Advice to Other States

- Change initiative lessons
  - Be flexible; don’t get overly attached to one idea and be willing to pivot
  - Try multiple change ideas at one time utilizing different provider partners

- Data lessons
  - Be aware of claims data limitations; consider the best ways to analyze the data
  - PowerBI is a powerful tool for analyzing and displaying data

California

Arlene Silva RN MSN, Nurse Consultant III, CA Department of Health Care Services

Kathleen Dalziel, Director of HEDIS and Accreditation – Health Plan of San Joaquin

Dorian Roberts, Senior Project Manager – Partnership HealthPlan of California

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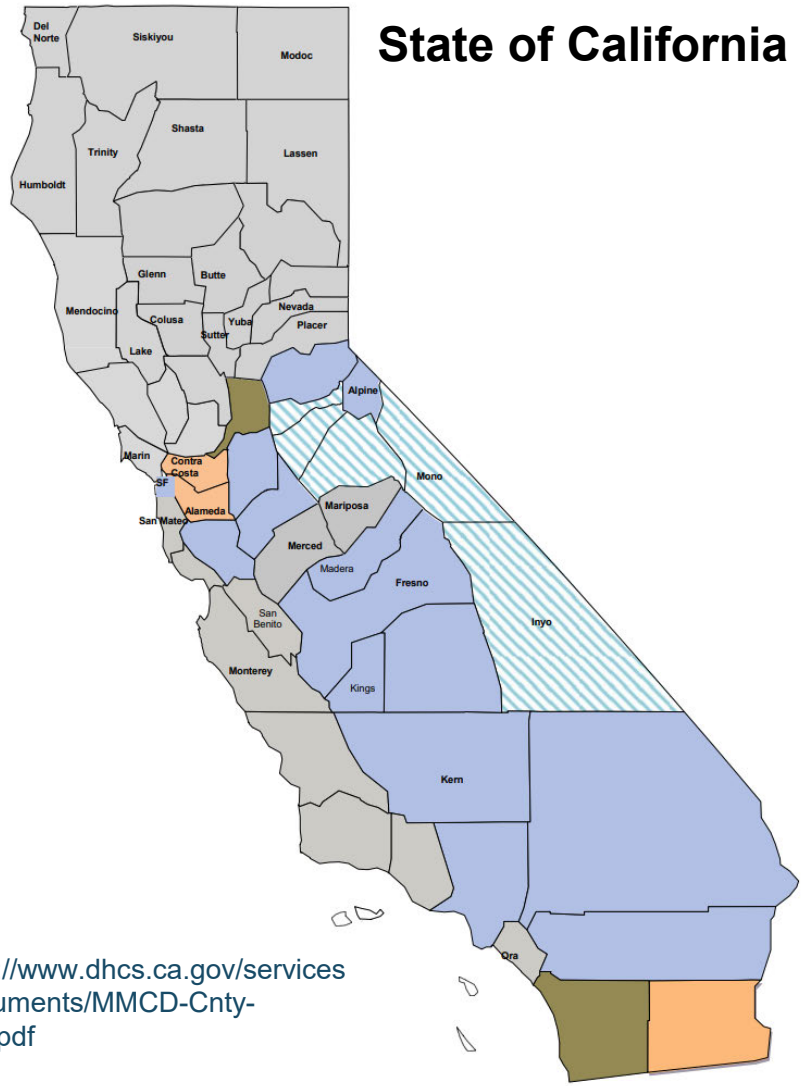
The Infant Well-Child Visit California Team

State of California



https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf

DHCS Quality and Health Equity Transformation Branch Nurse Consultants and EDIM Data Team

- Health Net Community Solutions (HN)
- Health Plan of San Joaquin (HPSJ)
- Partnership HealthPlan of CA (PHC)
- 4 FQHCs
- Hospital + Providers

Medi-Cal Excellence in Early Childhood Outcomes Collaborative Learning Community

Managed Care Plans
Children Now
State agencies
Stakeholders
DHCS

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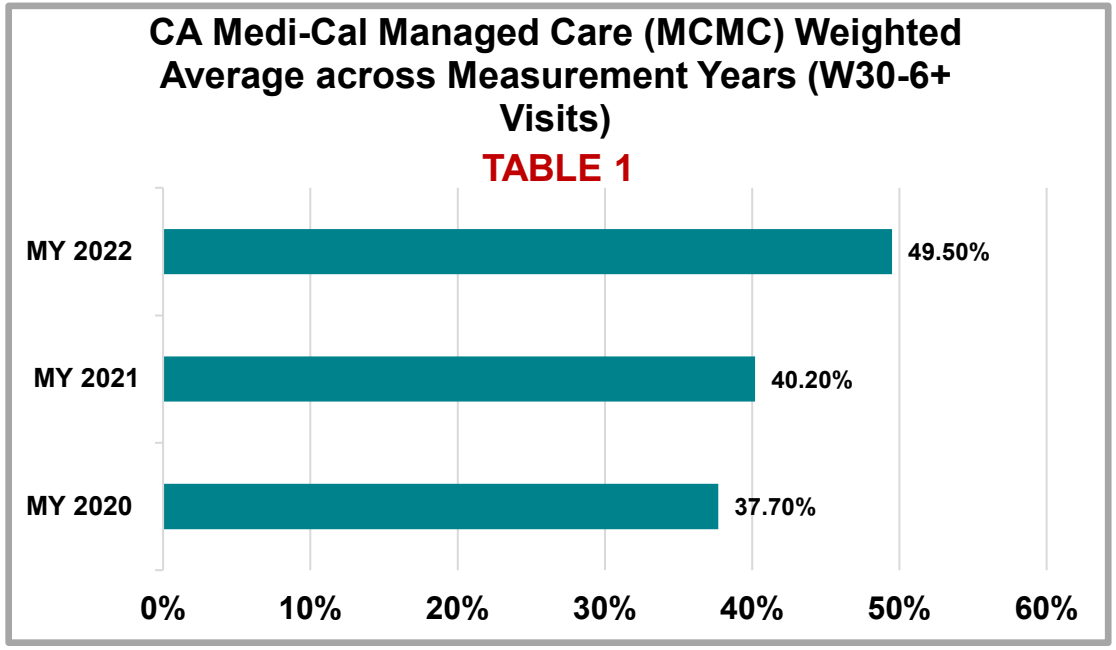
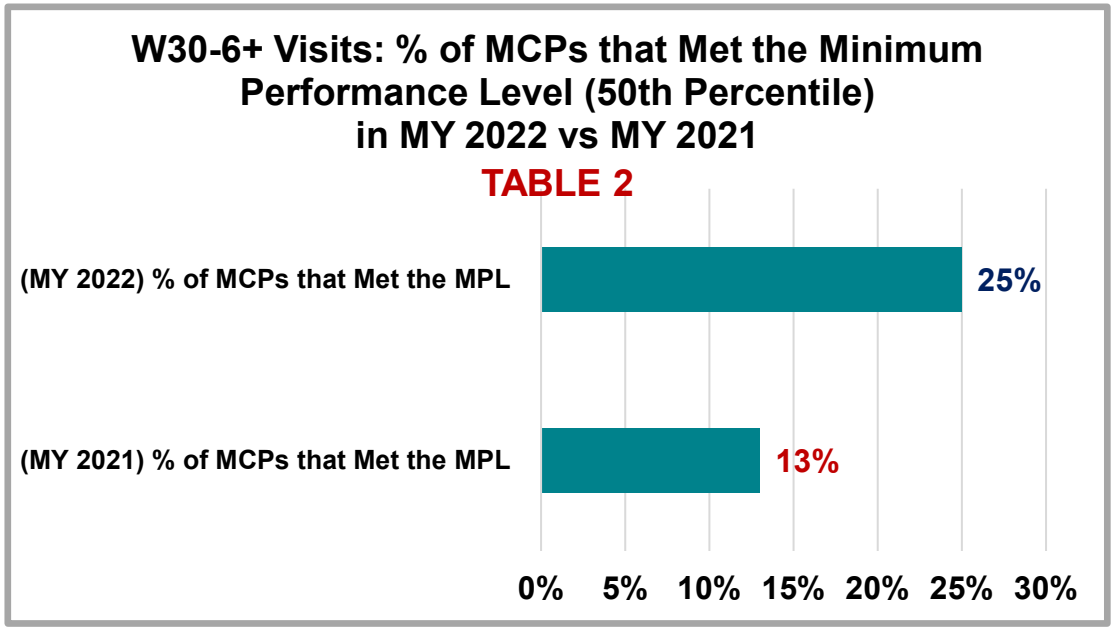
Background: California

- In Measurement Year (MY) 2022, there were **93,763** individuals enrolled in Medi-Cal and eligible to receive well-child visits in the first 15 months of life
- In MY 2022, CA DHCS is contracted with 25 Managed Care Plans (MCPs)
- There are a total of 56 reporting units managed by the MCPs





MY 2022: There was improvement in CA's MCMC weighted average and % of MCPs meeting the Minimum Performance Level (MPL) on W30-6+

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AG Project Aim Statement (California)

The Challenge

- Gaps in well-child visits occur within the first 6 months of life after birth

Our Aim

- The percent of children in intervention counties that complete two or more well-child visits by 6 months of age will increase by 10 percentage points from the 2021 baseline
- Reduce disparities for Black/African Americans by 10 percent from the 2021 baseline

Strategy

- Member engagement and outreach materials provided during prenatal and post-partum period **(HPSJ and HN)**
- Partner with hospital to schedule first well-child visit before discharge **(PHC)**
- Self-care member incentives for the Black/African American population **(HPSJ)**

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AG Project Aim Statement (HPSJ and HN)

The Challenge

- Low rates of well-child visit completion for infants aged 15 months especially prominent in San Joaquin County and Stanislaus County
- High social vulnerability and low Healthy Places Index (HPI) scores found in San Joaquin County and Stanislaus County

Our Aim

- To increase the rate of infants who receive 2 or more well-child visits by 6 months; Reduce health disparity for black infants by 10%
  Note: Health Plan of San Joaquin (HPSJ) and Health Net (HN) represent 100% of Medi-Cal covered lives in San Joaquin and Stanislaus.

Strategy

- Distribution of outreach resource checklist before delivery
- Follow-up touch points at third trimester and after delivery
- Engaging community to provide culturally relevant support to birthing parents

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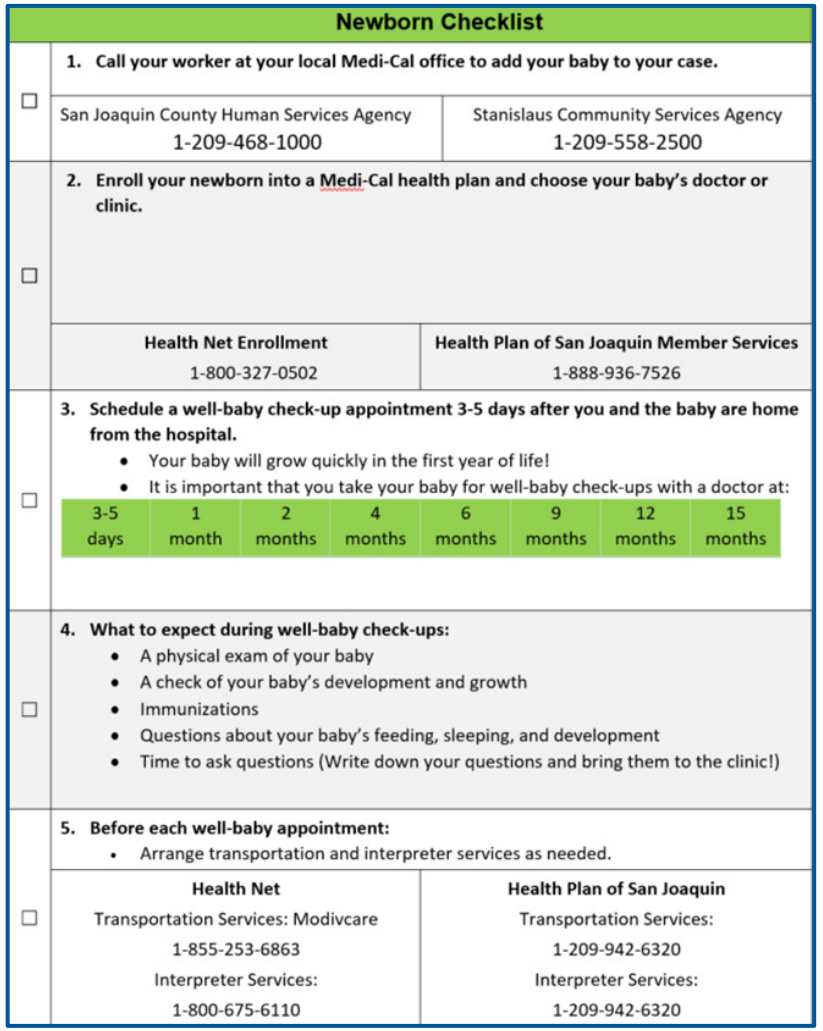
Strategies and Interventions (HPSJ and HN)

- Non-branded newborn checklist distributed to pregnant patients through four provider partners that covered
  - Newborn enrollment
  - Periodicity Schedule of well-child visits
  - What to expect in well-child visits
  - Resource numbers for transportation and interpreter services
- Ongoing data exchange with provider partners
- Follow-up calls, direct scheduling, language assistance
  - Expectant and postpartum birthing parents
  - Postpartum and infant well-child visits
  - Transportation to and from visits
- Partnership with San Joaquin Black Infant Health
  - Hosting prenatal and postpartum graduations
  - Milestone incentives
  - Health education
  - Checklist distribution

BLACK INFANT HEALTH (BIH)



Newborn Checklist

☐ **1. Call your worker at your local Medi-Cal office to add your baby to your case.**

San Joaquin County Human Services Agency	Stanislaus Community Services Agency
1-209-468-1000	1-209-558-2500

☐ **2. Enroll your newborn into a Medi-Cal health plan and choose your baby's doctor or clinic.**

Health Net Enrollment	Health Plan of San Joaquin Member Services
1-800-327-0502	1-888-936-7526

☐ **3. Schedule a well-baby check-up appointment 3-5 days after you and the baby are home from the hospital.**

- Your baby will grow quickly in the first year of life!
- It is important that you take your baby for well-baby check-ups with a doctor at:

3-5 days	1 month	2 months	4 months	6 months	9 months	12 months	15 months

☐ **4. What to expect during well-baby check-ups:**

- A physical exam of your baby
- A check of your baby's development and growth
- Immunizations
- Questions about your baby's feeding, sleeping, and development
- Time to ask questions (Write down your questions and bring them to the clinic!)

☐ **5. Before each well-baby appointment:**

- Arrange transportation and interpreter services as needed.

Health Net	Health Plan of San Joaquin
Transportation Services: Modivcare	Transportation Services:
1-855-253-6863	1-209-942-6320
Interpreter Services:	Interpreter Services:
1-800-675-6110	1-209-942-6320

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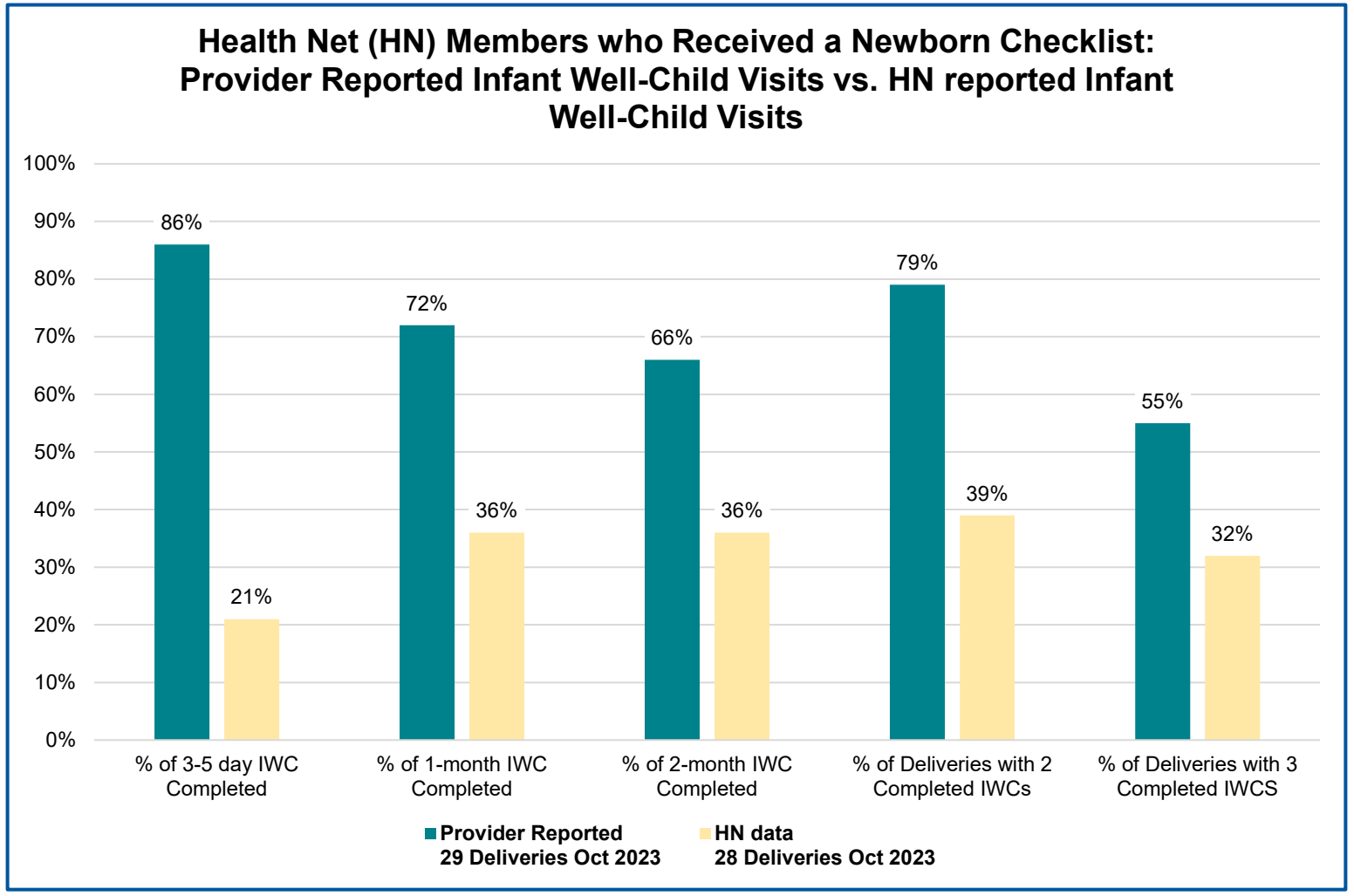
Measures and Data (HN)



- 33 Health Net members received newborn checklists
- There is a data gap between provider reported IWC and HN reported IWC
- Data lag also identified (more IWC visits identified in HN data in October 2023 (shown in chart) – 3 months after initial data run
- Lessons learned – HN initiated a data reconciliation project with HEDIS team for early IWC visits

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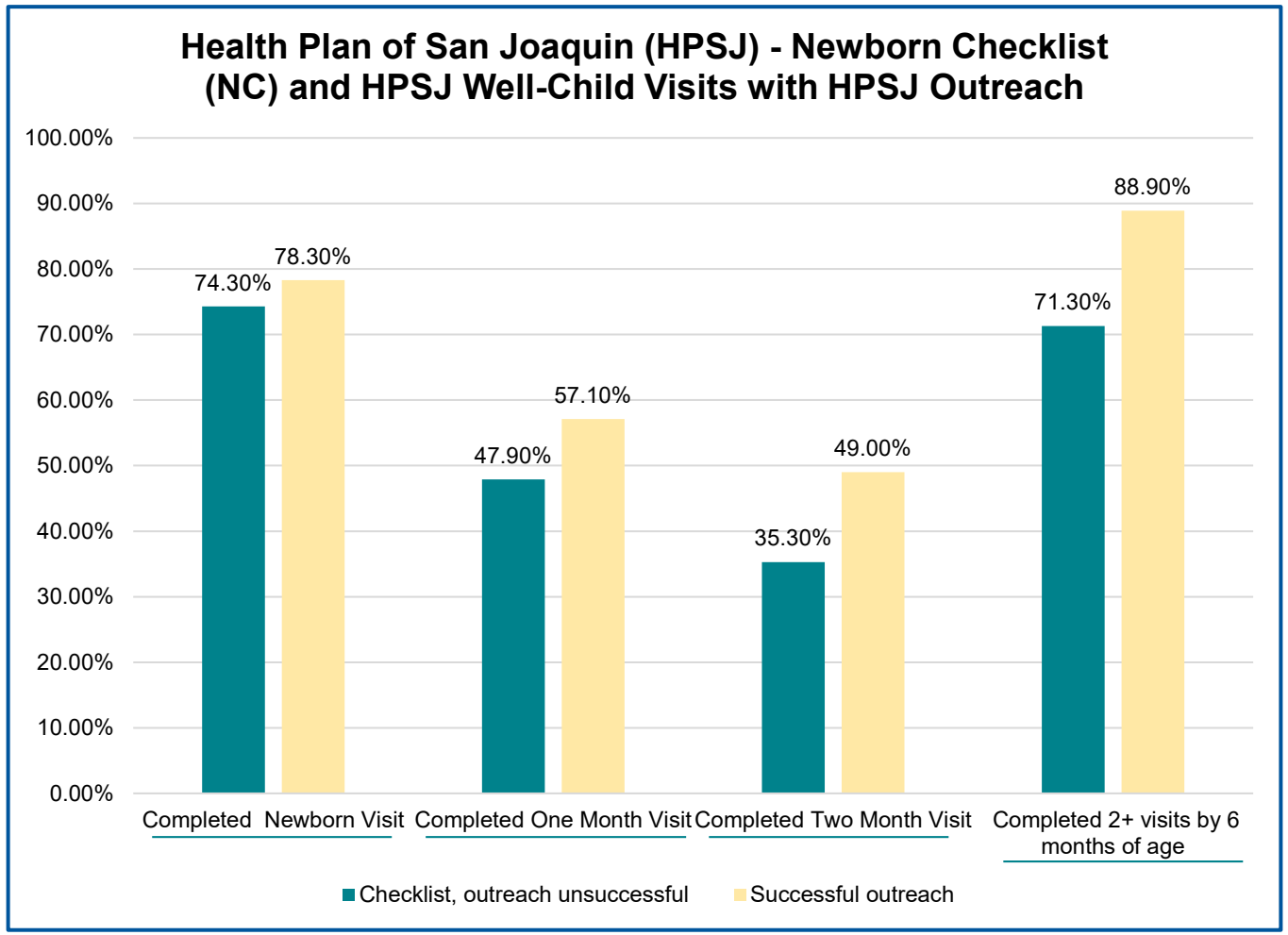
Measures and Data (HPSJ)



Data represents 365 infants who have turned 6 months after 1/1/2023

- When outreach and reminder call follow-up is coupled with tools to assist birthing parent with navigating the healthcare process, greater adherence to care is observed
- Culturally relevant care supports closing social factors that contribute to health disparities
  - There were 24 participants in Black Infant Health. Of those, 19 have delivered and 11 are 6+ months. All have completed 2+ visits by 6 months including one preemie who went home weighing 4lbs, 9 oz

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Spread and Sustainability (HPSJ and HN)

- All delivery systems participating in the project will sustain the process going forward
- Spread to local high-volume providers
- Sustain processes that are streamlined, abandon overly ambitious tangential projects
- Continue and invest in local community and culturally relevant care

Lessons Learned and Advice to Other States (HPSJ and HN)

- Engage executive leadership early
- Perform barrier analysis with subject matter experts in the field to assist with accurately identifying and prioritizing interventions
- Community awareness of the issues impacting subpopulations increases sensitivity to improvement
- Key informants provide great insights into system issues and social factors
- Use tools that address barriers and that provide education and resources to support process implementation
- Data can be instrumental in informing decisions
- Community resources can be the final step in addressing social factors and cultural barriers to care

AG Project Aim Statement (Partnership HealthPlan - PHC)

The Challenge	▶ Low rate of completion of recommended well-child visits for infants aged 15 months
Our Aim	▶ Improve the quality of care for Medi-Cal children ages 0-15 months by increasing infant well-child visits 10% over baseline and reducing targeted disparities
Strategy	▶ Connect pregnant members to a pediatric provider for their baby during their third trimester ▶ Partner with hospital to ensure first well-child visit is scheduled before discharge

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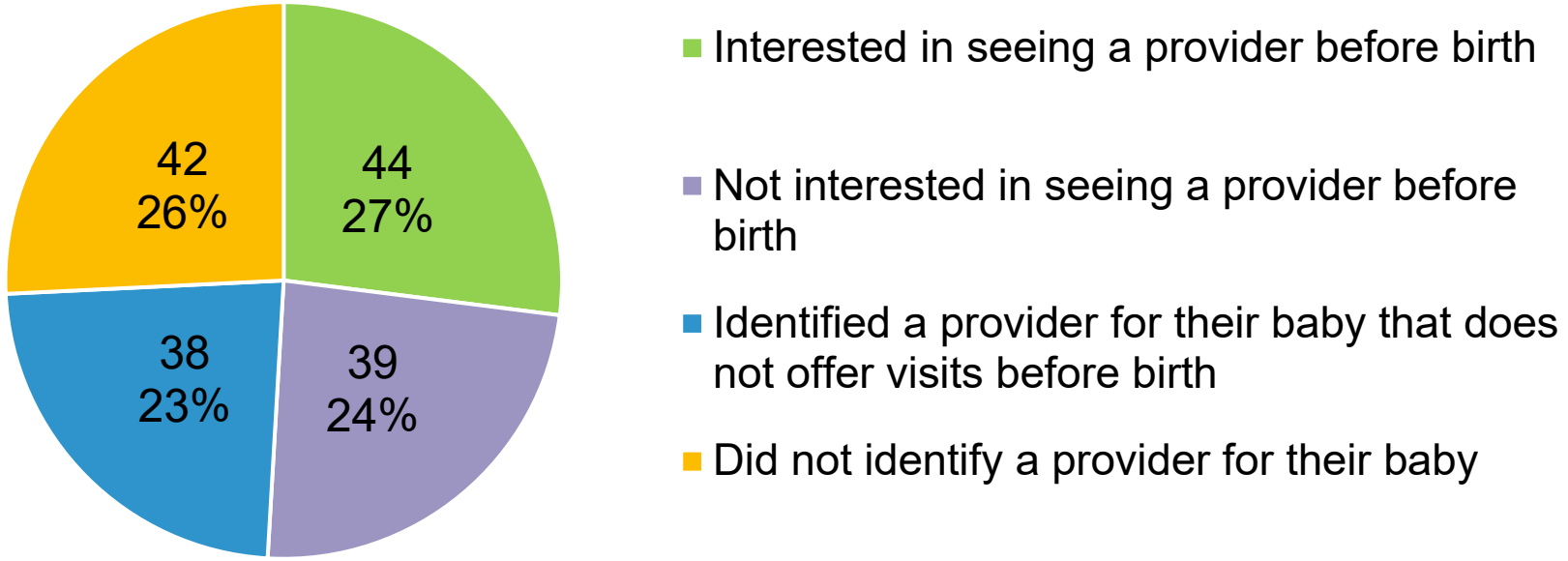
Strategies and Interventions (PHC)

- **Strategy 1:** Connect pregnant members to a pediatric provider for their baby during their third trimester through Partnership's Growing Together Program (GTP).
- **Intervention:** Member outreach via phone -
  - Of the 165 members in the intervention, 163 (98.79%) were reached and were:



  - The intervention was **abandoned.**

Barrier Analysis (PHC)

- Conducted an analysis on babies born in 2021 to identify which completed a first well-child visit within the first 2 weeks of life.

  Analysis included:

  - **Hospital** where baby was born
  - **Organization** baby is assigned to – to identify which organizations within Partnership network are most and least successful in achieving this metric
  - Baby's **county** information – to identify if there is an association between county and success in this metric

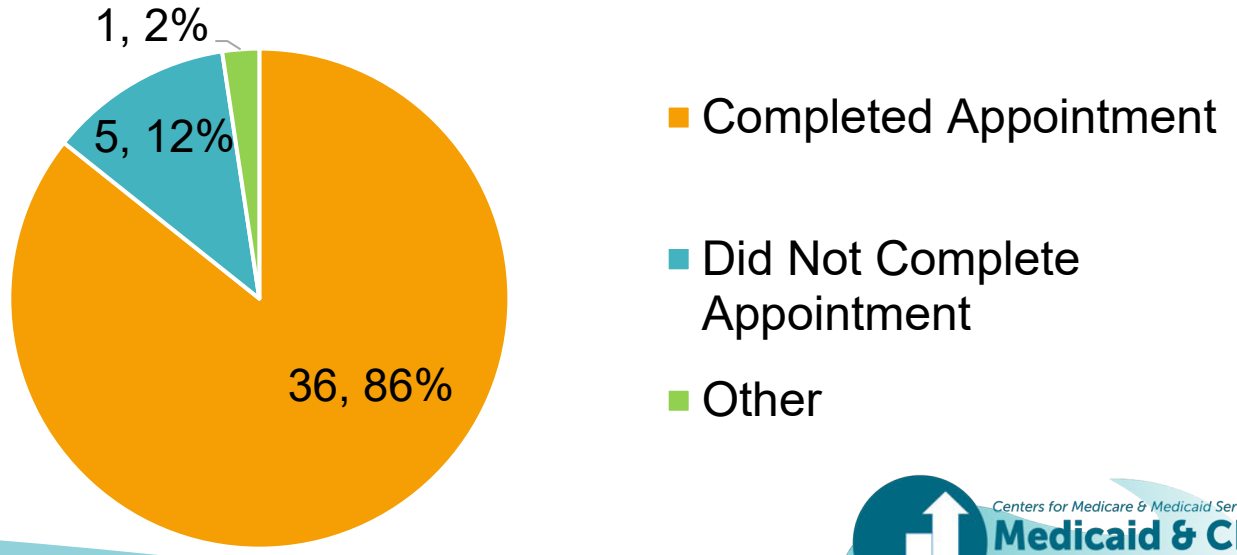
Barrier Analysis (PHC)

- Member feedback: Partnership's Population Health team called members assigned to organizations that were most and least successful to ask members about their experience in scheduling and attending their baby's first well-child visit.

What Led to Their Success in Completion	Barriers Faced
▪ Reminder calls before appointment ▪ Creating a relationship with provider during pregnancy and following ▪ Clear communication from provider about next visit before the end of the appointment ▪ Support and assistance from family and plan ▪ Gift cards ▪ Scheduled appointment in hospital and reminder ▪ Education and knowing visit is important	▪ Rescheduled appointments ▪ Not as many pediatricians in the area ▪ Working caregivers struggle to make appointments during business hours; recommended evening or alternative appointment times ▪ Member having to call and make appointment after birth ▪ Transportation

Strategies and Interventions (PHC)

- **Strategy 2:** Partner with hospital to ensure first well-child visit scheduled before discharge.
- **Intervention:** Partnership contacted members to ask
  - Did member attend their scheduled appointment and have next appointment scheduled?
  - Does member have any needs (e.g., transportation, childcare) to ensure they are able to make their next appointment?
    - Of members reached, status of appointment scheduled at discharge (Births from 2/16 – 5/15):



Lessons Learned and Advice to Other States (PHC)

- Delayed newborn enrollment can be a barrier to data capture
- Fostering relationships with organizations in network is key. Facilitating communication between different providers and provider types within network is important
- Hearing from members is essential when looking to make an impact on their care

Next Steps (California)

- Regional team collaborative approach integrating strategies on how to improve well-child visits
- Institute for Healthcare Improvement Children Sprint learning collaborative
- Convening member voices workgroup as part of the Birthing Care Pathway
- Newborn Hospital Gateway process to transition in 2024
- Relationship building with stakeholders that impact infant well-child visits (e.g., First 5 California, Black Infant Health, etc.)

Questions & Discussion

New! On-Demand QI TA

- **On Medicaid.gov**
  - QI tools to develop and implement QI projects
    - Driver diagram with evidence-based change ideas
    - Recommended measures for QI
    - “Getting Started with QI” short videos
    - Highlights from the 7 recent affinity groups
    - Previously presented topical webinars
  - Additional 1:1 support
    - MedicaidCHIPQI@cms.hhs.gov
- **Topics currently available**
  - Improving Infant Well-Child Visits, 0-15 months
  - Improving Asthma Medicaid Management
  - Improving Postpartum Care
  - Improving Fluoride Varnish in Primary Care
  - Improving Timely Health Care for Children and Youth in Foster Care
  - Improving Behavioral Health Follow-up Care
  - Tobacco Cessation Strategies
  - Using Managed Care Tools for Quality Improvement

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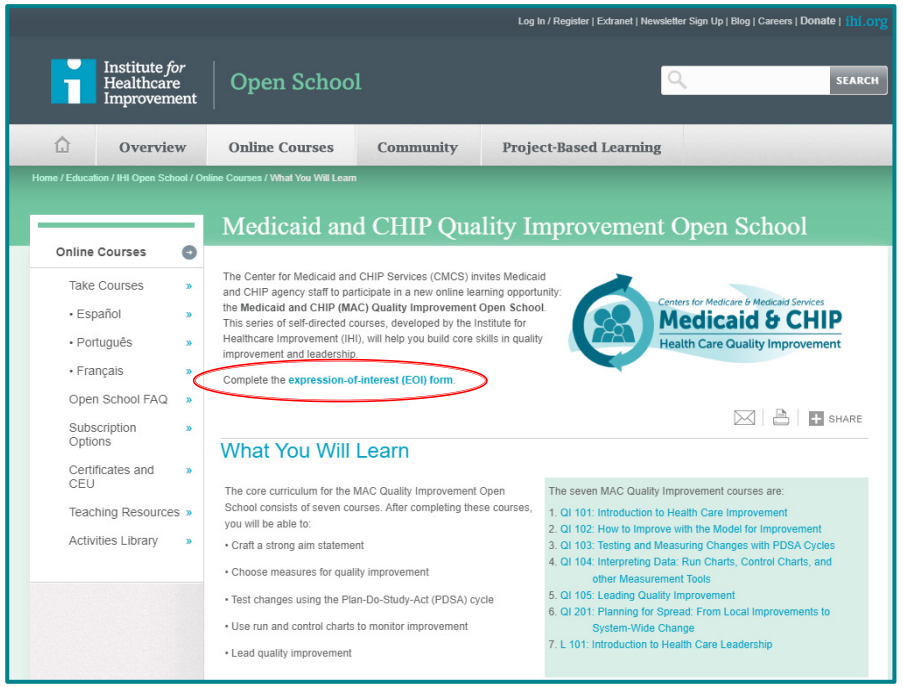
Medicaid and CHIP QI Open School

MAC QI Open School courses will help QI staff develop, strengthen, and use QI skills, including:

- Understanding and applying the Model for Improvement
  - How to craft an effective aim statement
  - How to choose and use measures for QI
  - Using PDSA cycles to develop strong programs and policies
- Access to the Institute for Healthcare Improvement's extensive resource library



To get started fill out an Expression of Interest (EOI) form at www.ihi.org/MACQuality

Questions? Email MACQualityImprovement@mathematica-mpr.com

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MAC QI Office Hours

MAC QI Office Hours

- Offered multiple times every month with an Improvement Advisor and/or with a Division of Quality and Health Outcomes, Center for Medicaid and CHIP Service staff
- There is no need to sign-up in advance
- Bring your QI questions

To learn about upcoming Office Hours, join the Office Hours distribution list by emailing MACQualityImprovement@mathematica-mpr.com

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