CMS AFFINITY GROUP STATE SPOTLIGHT WEBINAR: IMPROVING INFANT WELL-CHILD VISITS, 0-15 MONTHS

Transcript

Olivia Chan

Slide 1

Hello, everyone. My name is Olivia Chan, and I'm an analyst at Mathematica. Thank you for attending today's event titled CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits for 0-15 Months of Age. Next slide.

Slide 2

Before we begin, we will want to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. Closed captioning is available by clicking on the CC icon in the lower left corner of your screen. You can also click Control+Shift+A on your keyboard to enable the closed captioning.

We welcome audience questions throughout today's webinar through the Q&A panel, which is located at the bottom right corner of your screen. If you'd like to submit a question, please select All Panelists in the drop-down menu and then click Send to submit the question or comment. We'll be monitoring the Q&A throughout the webinar and will address as many questions as possible. And if you have any technical issues, please use that same Q&A panel to reach out to us. Select Derek Mitchell in the drop-down menu and then click Send to let us know how we can help.

At the end of the webinar, a survey will pop up. We're asking you to please respond and provide feedback to help improve future webinars. We also want to let everyone know that today's webinar is being recorded. We will send an email to all meeting registrants when the slides and recordings are posted on Medicaid.gov. Next slide.

Slide 3

For today's agenda, we'll begin with an introduction from our CMS team to discuss CMS' efforts to improve maternal and infant health and the importance of infant well-child care. I'll then give an overview of the Infant Well-Child Visits Affinity Group and highlights from our participating states, and I'll pass it off to our wonderful speakers from South Dakota and California, who will share more about their QI work in the affinity group. We'll have time at the end for a Q&A and end things off by sharing some quality improvement technical assistance opportunities offered by CMS. Next slide.

Slide 4

Now I'd like to welcome to the mic Kristen Zycherman from the Centers for Medicare and Medicaid Services. Kristen, I'll pass it to you.

Kristen Zycherman

Thank you, Olivia. I just want to welcome everybody for coming today. Next slide.

Slide 5

As you probably know, CMCS and the Division of Quality has a robust Quality Improvement Technical Assistance Program, which includes a lot of QI TA resources. More and more are going up, including our Infant Well-Child QI TA resources, which went up live today. So you can see those on our webpage. But our QI TA also includes our learning collaboratives, which generally consist of a webinar series, followed by an action-oriented affinity group, as we did in this case. Next slide, please.

Slide 6

The Infant Well-Child Learning Collaborative was part of our Maternal and Infant Health Initiative, or MIHI, and it was one of the areas of focus identified by our MIH expert workgroup. Next slide, please.

Slide 7

The MIHI had three main focus areas to improve outcomes for maternal and infants enrolled in Medicaid and CHIP, which are illustrated here. You can find more information on each of these areas on our webpage. Also, stay tuned for more information on our new QI TA offerings for 2024. Couldn't resist plugging those. The sneak preview is that the topics will include maternal mental health and SUD, and maternal hypertension and cardiovascular health. So stay tuned for more information on those. Next slide, please.

Slide 8

Back to the topic of today, infant well-child care. As I'm sure you well know, there have been many well-documented benefits of infant well-child visits for both infants and their caregivers, including assessments of physical and mental health screenings, immunizations, care coordination, as well as caregiver education and screening. Next slide, please.

Slide 9

But there is huge state-to-state variation on whether infants are achieving the recommended amount of well-child visits. The measure that this affinity group was tied to was the W15, which was then modified to W30 starting in FFY 2021, in that 2021 core set. Then, W30 has a rate for 0 to 15 months and 15 to 30 months. This is the first 15 months of life split out by state, and you can see it varies from a low of 28.2% to a high of 77.4%, with a state median of 57.5%, so plenty of room for improvement. We're very excited of all the states that joined us for this affinity group. Now I am going to hand it back to Olivia.

Olivia Chan

Slide 10

Great. Thanks, Kristen. Now I'll be sharing an overview of the Infant Well-Child Visits Affinity Group. Next slide.

Slide 11

Our affinity group began in December 2021 and closed out recently in December 2023. Throughout the affinity group, we had six participating states, California, Missouri, North Carolina, South Dakota, Texas, and Virginia. This action-oriented affinity group aimed to support states' Medicaid and CHIP programs and their partners in designing and implementing quality improvement projects to improve infant well-child care in their state. Next slide.

Slide 12

To get a flavor of the projects that state teams worked on, we'd like to share some affinity group state highlights. For California, we'll be hearing more from them later in this presentation, so I'll start with Missouri. The Missouri state team focused on improving well-child visit rates among populations and regions chosen by their partners. They partnered with three managed care plans to test whether electronic health record patient portals, desk references, and managed care member incentives would improve visit attendance. North Carolina aimed to align with QI work within the state's newly implemented managed care program. They partnered with the five Medicaid managed care plans in their state and are working to integrate their state's quality strategy into their infant well-child quality improvement work. Next slide.

Slide 13

We'll also be hearing more from South Dakota, so I'm going to move to Texas. Texas focused on addressing disparities in well-child visit rates in their state. They formed a learning collaborative of 10 managed care plans in their state, and these plans developed QI projects specific to the needs of their service populations and tested ideas such as scheduling assistance, tiered and multimodal reminder/recall outreach, and member incentives. Texas will also be presenting at this year's CMS Quality Conference, which will be taking place from April 8th through 10th. If you haven't already, feel free to register through the link we just put in the chat so that you can hear more from Texas. Last but not least, we have Virginia. The Virginia team focused on improving visit attendance within specific regions within their state and partnered with four managed care plans to test the impact of Medicaid enrollment assistance, scheduling assistance, addressing barriers, and enhanced case management and care coordination. Next slide.

Slide 14

Great. Now, it is my absolute pleasure to welcome the South Dakota team to the floor. We have Ashley Lauing, a policy strategy manager, and Samantha Moon, a senior data analyst from the South Dakota Department of Social Services. Ashley, on to you.

Ashley Lauing

Thank you so much, Olivia. Can we go to the next slide, please?

Slide 15

We're going to start with just a brief background of South Dakota in terms of Medicaid. I always feel it's important that we do a level set with who we serve in South Dakota as each state is definitely unique, and each state has unique challenges based on their populations. South Dakota is a fee-for-service state. We do not have any managed care in our state. We are the single state Medicaid agency. That brought with it a lot of benefits, that we'll touch on mostly in our data analytics, and we saw some other folks may not have had easy access to some of the information that we did because of that. In our state fiscal year 2023, one in six South Dakotans were on Medicaid or CHIP. Twenty-three percent of all children born in South Dakota are born on Medicaid or CHIP services. Forty percent of children born in South Dakota will be on CHIP or Medicaid within the first year of their life. Two in every five children under the age of 19 has coverage through Medicaid or CHIP. We did not become an expansion state until July of 2023, so this information is all based on before expansion. As you can see, 68% of all recipients in South Dakota were children, before expansion. So that just talks a little bit about who we served up until

that point and the population at large that we felt we had an impact on during this QI project. Next slide, please.

Slide 16

So our challenges are on here. Less than 50% of our recipients under the age of 15 months received their six recommended well-child visits. We also noted that that median has been decreasing across all states. So it's not a unique problem to South Dakota. We just happen to be, as you all saw, in that lower percentage. Then we also noted that rates for our AIAN population are almost less than half of that for the remaining population. So we knew that that was a large target area for this QI project. So our goal was to increase the percentage of those recipients meeting the HEDIS measure by 10 percentage points to 30.6%. It would also increase our overall state rate as our AIAN population accounts for 36% of our Medicaid population as a whole. Then our strategy, we called it a multifaceted approach, but I think the majority of folks who've worked with us know that we kind of used—we called it a "spaghetti philosophy," right? We were going to throw things at the wall and see which one stuck. It made it unique, it made it fun, and it allowed us to just engage on so many different levels with different groups to just see what we could find that might work. Next slide, please.

Slide 17

As you'll see here, there's quite a few interventions we tested in a very short period. That is thanks to a lot of great work inside of our own department of finding ideas. It is also thanks to a lot of our great partners. We're very fortunate to have some outstanding partnerships with local tribes, with IHS, Urban Indian Health, some 638s. We had great, great partners which made all of this possible. But some of the things that we did were we had moved a billing form change, as you can see up there, in an attempt to better capture well-child visit attendance, just due to the way that those are generally marked on a UB04. We tried a rack card incentive. It was our easiest one to track. Basically, providers were given rack cards and asked to speak with their recipients and then have the recipients leave with a tangible product that reminded them of how often their child should receive well-child visits.

We did some culturally tailored messaging. We worked with providers to track acute care visits that were transitioned into a wellness visit when appropriate. We had a lot of people call in for immunizations only, that we asked to transition to a full well-child visit for this age range. Then some of the partner strategies were—IHS came to us with an idea of wanting to set aside days where they just did well-child visits. They had providers on hand to just do those. Then they would pair it with incentives. And they had asked us about just doing some well-child visit fairs. We had worked with a couple foundations to provide some incentives and incentive cards to see if that was addressing what we thought was a big barrier to care in our area. Then, of course, we just are trying as many different modes of communication including listserv messaging with both providers and recipients.

We really did just try and hit this from every angle we possibly could think of and tracked those results and outcomes to see, is there something that really has an impact? Next slide, please.

Slide 18

I am going to turn this over to my colleague, Samantha, to talk about our data analytics and some of our struggles and wins that we had with that.

Samantha Moon

Thanks, Ashley. The goal of the data team with this project is to track the effectiveness of the PDSA. We actually had a few attempts before we landed on our final tracking document measure. The first attempt was just to calculate that W15 or W30 measure as is—used the specifications which are, as I'm sure you guys are aware, pretty yearly-based. They are intended for yearly calculation. That means that everything is not going to be real-time data which gives a lot of limitations as to, okay, was this PDSA effective? We can't necessarily look at it as fast as we would like. Those can be modified definitely but, with looking at the eligibility requirements and things that the HEDIS measure does, that provided some limitations.

Then the second attempt was to just look at the overall number of wellness visits each month, right? Just the number doesn't give us a lot of information though. It can be misleading. Maybe a good amount of children didn't turn the age in a certain month that would require them getting their visit done that month. So that's why it says right there—not normalized across months; it just kind of depends on who's in that denominator, who's eligible to get a visit. So that didn't work out either. We thought we wanted to kind of normalize it. So this is where we landed.

Our third attempt was to compare the actual number of visits expected with the expected number of visits. The measure there is the actual over expected, expected being based on this periodicity schedule that we have and that we provide to our recipients and to our providers as well; it's on our website, outlining that children should have their wellness visits at 0, 1, 2, 4, 6, 9, 12, and 15 months. That, obviously, is well above and beyond that six baseline that the HEDIS measure outlines—the six plus—right? That's the periodicity schedule, and that's where we get our expected number of visits. That's where we get our denominator.

I gave an example here. For a given month, let's say there were 1,071 visits expected based on recipient age, American Indian/Alaskan Native, for this case where we drilled in. Age and eligibility in the Primary Care Provider program, that's how we linked data to clinics, was based on that. So not necessarily where they got their visit, but who's their PCP. Then 442 occurred, then that would give us the rate of 41.27% for that month. So we're able to kind of see it on a monthly basis, which gave us a lot of flexibility. We can look at trends, look at moments in time, kind of what happened. We were able to explain a lot of what happened based on those events that IHS was putting on, that Ashley touched on. But of course, with anything, there are some limitations.

With this one, it could be considered too restrictive, with that it's more than six that we look at—it's 0, 1, 2, you know. Definitely, we look at all of those dates, so that could be too restrictive, especially too when you're looking at claims, there is a bit of a lag, right? So that's kind of a limitation as well. Maybe we're saying this recipient should have got one in this month, but we don't get the claim for it until the next month, right? It's kind of that strict specification there, which the HEDIS measure has a similar thing, but it's on a yearly basis. So just some small limitations there.

If we can go to the next slide, I'll show you, this is the chart that we landed on that shows the actual over-expected number of visits by month.

Slide 19

It was done in PowerBI, which was really beneficial for us, because then we could move and filter as needed. We could filter for specific clinics and drill into specific age groups. We did, like I said, and as Ashley talked about, specifically look at American Indian and Alaskan Native recipients, but we could

also filter by race as well. This blue line is the IHS clinics (like we've been saying, we partnered a lot with IHS and were really interested in their programs and incentives that they were implementing) compared to the light green/light blue line for everybody else. That includes IHS as well, but it just kind of gives a comparison, right?

Compared to everybody, how is IHS doing for those AIAN recipients? This gave us a good look as well, with those tall black lines, where we could see, okay, this is when maybe—hopefully—a change could occur. Whether that was when, for example, IHS switched how they billed or when the affinity group started, when we did some of our other PDSAs, or provider communications, things like that. This was a great tool for us to look at, and it was refreshable, super easy. This is where we landed, and it gives us a good visual, month over month. If we want to go to the next slide, I will pass it back to Ashley.

Ashley Lauing

Slide 20

Awesome. Thanks, Sam, for diving into that data. Sam is definitely our data expert, so I'm glad that she was able to join us today. As we started to look at our spread and sustainability, we really focused on things, of course, that we could just take forward with us that were easy to implement, that providers could get on board with, and facilities could get on board with pretty easily. We've got one provider who's working with a foundation on finding other initiatives. I kind of touched on this a little bit, but one of our PDSAs tested whether or not a fuel card would have an impact on attendance, where we gave moms a fuel card at 38 weeks gestation and asked them to use that to bring baby back to their first well-child visit. Then from there, they would receive another fuel card. We do hear a lot that transportation is a large issue in South Dakota. Much to our shock, it actually did not have an impact. But as we started asking recipients what they would like, the bigger impacts were diapers, formula, bottles, wipes, Pack-and-Plays, those types of things.

That foundation took that and ran with it. They're going to be looking at different incentives, and then reporting back to us really how things go. We've got them working with focusing on just trying to be more flexible, trying different outreach. We did implement just not too long ago, January 1st, a new pregnancy program, which is directed at our prenatal/postpartum population. But it does require all providers that are participating in that program to use the PDSA process that we learned to address barriers to care initiatives. So that's great. Then they are also required to provide education on the importance of newborn and well-child visits. Then we're just really trying with continued communication efforts, keeping this at the top of everybody's list, that this is something that we really want to improve in South Dakota, and that we really want to take care of our next generation. Next slide, please.

Slide 21

I'll touch on the challenges. Sam had mentioned it very quickly; our claims runoff in South Dakota is six months. So our most accurate data is six months old, which makes tracking projects on a large scale incredibly hard. Because by the time we actually have any real information, we've maybe quote-unquote missed the boat. Right? So we did a lot of small-scale testing. That was a challenge for us to kind of get on board with. I know we kind of fought with CMS a couple times, but it ended up being for the best. That allowed us to get real snapshots immediately at the impact we were having or weren't having. We had some competing priorities, as the slide says. During the same timeframe, we had Medicaid expansion.

Of course, as you're all aware, we had a public health emergency. We had a public health emergency unwinding. We had the pregnancy program. For a small division of staff, we had just quite a few things going on that, towards the end, led us to just not having as much time to dedicate as we would love to have had. Then we did have some of our ideas that we asked providers or systems, “hey, you know, we'd love to test this idea.” And they very honestly said, “no, I don't think that's going to work; we want to do something different,” or whatever it may be. So those were a lot of our challenges that we encountered. But each one of them led to us finding something new, something better, or just rethinking our contributions and the asks that we had of providers. Next slide, please.

Slide 22

This is always my favorite slide, lessons learned and advice to others. Be flexible, right? There were many times that we just got asked, “oh, no, we don't want to do this,” or “can we change this,” or “can we move from this, this isn't working,” whatever it may be. Our ability to say, “you know what, yep, let's find a different way to do it, let's can what we've got and scratch and start here,” was really important and really gave us probably, I would say, some of our best ideas. Then if you've got multiple partners, try different ideas. Ask one to do it one way. Ask another to do it another way. That was our biggest support, was having great partners who were willing to just go with us when we needed as well. Then data lessons. Sam had touched on this also, being aware of those data limitations and really looking at what is the best way to take this information that we have access to and make an impact and using that information. She also mentioned this PowerBI—was just a beautiful tool that we got to use. It painted such a vivid picture for our providers to get their buy-in as well. So those were really just our big lessons learned. Be flexible and invest in some really good technology. And I think, Olivia, that is it from us, if I'm correct.

Olivia Chan

Great. Thanks so much, Ashley and Sam, for that wonderful presentation. Next slide.

Slide 23

Perfect. So next up, I'm excited to introduce the California team. We'll be hearing from Arlene Silva, a nurse consultant from the California Department of Health Care Services, and two of their managed care partners, Kathleen Dalziel, the Director of HEDIS and Accreditation from the Health Plan of San Joaquin, and Dorian Roberts, a senior project manager from Partnership HealthPlan of California. Arlene, the floor is all yours.

Arlene Silva

Thanks so much, Olivia. Good afternoon, everyone. For this affinity project, I'd like to acknowledge our Medi-Cal managed care partners, which we call MCPs—Health Net, Health Plan San Joaquin, and Partnership HealthPlan—in synergizing their efforts with their providers and community partners in impacting infant health. Our gratitude also goes to our DHCS QI colleagues and our stakeholder Children Now, who is also involved in this project. Of course, CMS also gave us the opportunity to share our learnings as well. Next slide, please.

Slide 24

California has 58 total counties. In measurement year 2022, there were 25 Medi-Cal managed care plans, which I'll call MCPs, operating within California. Some MCPs have more than one or multiple counties that they operate in, which we call MCP reporting units. We have a total of 56 reporting units

across California. Some counties may have two or more MCP reporting units to serve a large number of populations. The image on the right that you're seeing illustrates how we all work in this affinity project by forming a learning community facilitated by our stakeholder Children Now. We have learning forums with a goal of improving preventative health services for infants. Next slide, please.

Slide 25

So how is California doing in this measure? Table 1 in this slide looks at how California is improving, using the California Medi-Cal managed care weighted average from measurement year 2020 through 2022. Prior to the start of the affinity group in 2020, California's weighted average was low, and in two years increased by more than 10%, which we are really proud of. The second table shows a 50% jump of MCP units that met the DHCS standard, which is the 50th percentile of the National Committee for Quality Assurance, which is the NCQA Compass. This benchmark is our minimum performance level within the state, which we call MPL, that we set for our MCPs. To provide context, out of 56 MCP reporting units in California, there were 14 that met our standard compared to measurement year 2021, where only seven MCP units met the standard. So we admit we still have a lot to do in this space. Next slide.

Slide 26

During the early phase of our project, we realized that the gaps in well-child visits occurred within the first six months of life after birth. Based on the barrier analysis performed by our three participating MCPs, most challenges were because of the delay in the enrollment process for babies of our birthing members, access issues such as transportation, and navigating through scheduling and having a provider assigned to our newborn members. California has an ambitious goal to improve this measure. In this presentation, three of our MCPs will discuss how they leverage our prenatal care systems and their relationships with their providers up to postpartum, including the participation of a hospital, provider clinic sites, and community partners. Without any further ado, I'd like to introduce Kathleen Dalziel, who is our HEDIS Director from the Health Plan San Joaquin to talk about their affinity project along with Health Net.

Kathleen Dalziel

Thank you, Arlene, and good afternoon. Next slide, please.

Slide 27

So in alignment with the goal of increasing well visits for infants, the team focused on the first six months of life, as Arlene mentioned. The data investigation and analysis showed that if infants completed two or more well visits in the first six months, they were more likely to complete six in 15 months. In addition to the low rate of infant well visits, a racial disparity was identified in the infants whose birthing parents identified the infant as Black or African American. Along with the low rate of infant well visits, the areas of San Joaquin and Stanislaus Counties have, on average, lower Healthy Places Index scores, which indicate high social vulnerability. In order to address barriers in completing well visits and to provide support to birthing parents, the health plans, health center partners, and Children Now contributed to creating a newborn checklist, which helps a birthing parent navigate newborn enrollment, the managed care health primary care processes, and provide resources to the caregiver for accessing interpreter services and transportation. Next slide, please.

Slide 28

The newborn checklist explains how to enroll, when to schedule visits, what to expect at those well-child visits, and the numbers to call to schedule transportation and interpreter services. In addition to the newborn checklist, Health Plan of San Joaquin outreached to the birthing parents to help them schedule appointments and warm transfer them to their provider to schedule appointments, and the plan offered incentives for completing care. To meet the cultural needs of the Black and African American members, the plan partnered with Black Infant Health. Black Infant Health is an organization that provides both prenatal and postpartum classes and offers graduation ceremonies for the birthing parents who complete the required numbers of classes. Health Plan of San Joaquin hosts the graduations, provides health education and self-care incentives for participating in prenatal and postpartum classes, as well as offers the checklist. Next slide, please.

Slide 29

Here we have Health Net's data. This slide shows the data gap that Health Net found in the infant well care visits reported by the providers and the data received by Health Net. The green bars show that provider-reported percentage of Health Net members who received a newborn checklist during pregnancy who completed the well care visits in the first two months of life. The yellow bars are the Health Net-reported data. As the chart shows, there's a discrepancy between the provider-reported data and the Health Net data. This data gap led Health Net to initiate a data reconciliation project with the HEDIS team for completed infant well care visits. Other health plans have also identified a data gap, and they are working to reconcile data with providers. Next slide, please.

Slide 30

This slide shows Health Plan of San Joaquin data. The rate of two or more well visits by six months are compared for caregivers who received the checklist before delivery compared to those who received the checklist and successful outreach by telephone. The data captures members who have turned six months of age by January 2024. All members received the newborn checklist, so you can see that the bars on the left side of each segment reflect the well visit rate month by month.

Next, the plan measured the well visit rates by month for those who also had at least one successful follow-up call. Even though the completion rates do dip, you can see that the outreached members are still completing care at higher rates. But what is really spectacular is what is happening through the Black Infant Health program. Black Infant Health provides a community of people who support birthing parents from the prenatal period through postpartum and beyond. In coordination with the Black Infant Health activities, Health Plan of San Joaquin hosts both prenatal and postpartum graduations and offers health education along with the newborn checklist.

Of the 24 birthing parents who have participated in Black Infant Health since the plan established the partnership, 19 have delivered, and 11 of those infants are six months. Now, here's what's absolutely amazing. All of these infants, including one premature infant, have completed two or more well visits by six months. This is really phenomenal, including a preemie who weighed four pounds, nine ounces. Completed well visits for those members who had successful follow-up calls and reminders have an impact on the ability to complete visits. Next slide.

Slide 31

To sustain this project, the delivery system partners that we participated with are committed to sharing the checklist going forward, and Health Plan of San Joaquin is going to spread to other high-volume OB

providers. Also, to sustain the processes, we want to make sure that any overly ambitious tangential projects are going to be abandoned. We want to stick to the core work and continue the good work, and Health Plan of San Joaquin will continue and invest in local community and culturally relevant care. Next slide.

Slide 32

Here are some key learnings. Please take a moment to read through them because each and every one is critically important, and we learned a lot. Engage your executive leadership early to get buy-in. Involve your key informants. Data, as we've heard in other presentations and this one, can be instrumental in forming decisions. And don't forget, your community partners can be the final step in addressing the social factors that create barriers to care. Next slide.

Slide 33

Okay, now handing off to Dorian Roberts. Thank you.

Dorian Roberts

Awesome. Thank you so much, Kathleen. As mentioned, the three health plans in California's affinity group decided our state group's focus would be to positively impact well-child visits in the first month of life, and I'll get into Partnership-specific strategies on the following slide. Next slide.

Slide 34

Something that was mentioned in our affinity group was that it's a benefit that pregnant members are able to have a visit with their baby's provider before giving birth. So we decided that was something we wanted to explore and impact with our intervention. Our original goal was to impact pregnant members before they gave birth. The thought was connecting these members to their baby's provider before birth would help to establish care and positively impact attendance at those early well-child appointments. However, we later learned in our affinity group that there's no billing code for providers to use for this service, which made it hard to track. Although there were members that indicated that they were interested in seeing a provider before birth, none wanted to be connected by Partnership to schedule that appointment. So ultimately, we decided to abandon this intervention. Next slide.

Slide 35

After abandoning, we really wanted to take a closer look and see which regions had the highest and lowest rates of completion of well-child visits within the first two weeks of life. These are some of the metrics that we considered. Next slide.

Slide 36

During this brainstorming phase, our Population Health team made calls to members assigned to providers with the highest rate of members completing a well-child visit in their first two weeks of life to get their feedback and understand what led them to be successful in completing that early visit. They also made calls to members assigned to clinics that had lower rates of completion of well-child visits within the first two weeks to understand what barriers they faced that may have hindered them from attending an appointment within that time frame. Next slide.

Slide 37

Using the learnings and insights gathered from our analysis and member feedback, our strategy for our second intervention was to focus on the connection between the hospital and the clinic. For this intervention, we created a better connection point between one of our hospitals and the clinics served by that hospital to ensure that all members had their first well-child visit scheduled before discharge and that this appointment was communicated to the clinic the baby was scheduled to be seen at.

Our Population Health team then conducted calls to the members included in our intervention to ensure they attended the appointment that was scheduled at discharge. They were able to address any barriers faced by members that didn't attend that scheduled appointment and also ensure that the members' next well-child visit was scheduled. In doing so, we found that 86% of the members that were reached by our Population Health team attended their appointment that had been scheduled at discharge. We were also able to follow up with members that didn't attend that appointment and assist them in rescheduling if needed, which was ultimately successful. Next slide.

Slide 38

As for our lessons learned, something that was highlighted in our work, as well as our plan partners', was the barrier of newborn enrollment to data capture in California. From our participation in this group, we've been able to learn from other plans and from other states discussed with DHCS, and this has led to the development of potential solutions to a barrier we currently face in California. We have also seen that our relationships with our organizations have not only been key in getting their buy-in, but also in facilitating a connection between different provider types, which has benefited our members. Lastly, hearing from our members has been key in addressing the barriers they're facing and ensuring the changes and strategies we develop make a positive impact on their care as well. Now I will pass it back to Arlene.

Arlene Silva

Slide 39

Thanks so much, Dorian. So as a state, within California we have multiple meaningful learnings brought by this affinity project. There are multiple activities going on at the state level in engaging our partners and members to improve infant well visits. So in a few sentences, this is what we are doing so far. To reduce administrative burden for our health plans, DHCS is looking at standardizing the reporting of births of infants with a more expeditious enrollment of newborns into coverage and into a health plan through the Children's Presumptive Eligibility Online Portal, which will be effective July 2024.

We're also continuing to engage and develop partnerships through different forums to allow a more coordinated and synchronized approach that can benefit our Medi-Cal members. Again, our main message here is really collaboration goes a long way through relationship building, partnership, constructive and consistent communication, and collaborative problem solving. Of course, as a state, we would like to see sustainable interventions. We are proud of our incremental wins and our progress. Through continued partnership, it is our goal to scale and implement meaningful and impactful interventions. With that said, I'll pass it over to you, Olivia.

Olivia Chan

Slide 40

Great. Thank you so much, Arlene, Kathleen, and Dorian, for sharing the great work that California has been doing. Now we'll be moving into the Q&A portion of this event. Please submit any questions you have by typing into the Q&A panel, which is located at the bottom right corner of your screen. When submitting your question, please select all panelists in the dropdown menu and click send to submit the question. So we have a decent amount of time for Q&A. We have more than ten minutes, so feel free to take some time to think of any questions. We have a few questions that came in during the presentation, so I will start with those. All right. So I think I heard that culturally relevant care was mentioned by both the South Dakota team and also from Kathleen. I think it was with South Dakota, with the creation of culturally appropriate messages. And Kathleen, I believe your work with the Black Infant Health program and your tip to address social barriers to care. So maybe this is a two-part question. I'll pass it to Ashley first. Could you say more about how you developed the culturally appropriate messages with your team and with other partners?

Ashley Lauing

Yeah, absolutely. Like all good projects, we started with some good old fashioned Googling. We did a lot of research actually on what culturally tailored messaging looks like, what makes it appropriate versus inappropriate. Then we took that information and sent it to our communications team, who is absolutely stellar. They developed some initial images and then we presented those to all of our tribal partners. We wanted to, first and foremost, make sure that the Lakota that we had used was appropriate. It was correct. It fit across the state as best as possible. Then, from there, they provided feedback. Interestingly enough, one of the feedback that they had given us was that they had asked us to leave off all references to immunizations because parents that they had seen were really great about getting their children in for immunizations—which most of them would call and say, “my child needs shots” or whatever. But then they wouldn't get a full well-child visit because that phone call triggered a nurse-only visit. So they had specifically asked us actually just to leave references to immunizations off of most of our culturally tailored messaging.

In hopes that when parents would call in, they wouldn't say they wanted a vaccine or an immunization, that they would just call in and say that they needed their well-child visits. So they were instrumental. Having those partners that could review the language and the imagery that we used and providing us with some really important cultural emphasis to put on it, such as they had indicated that target or when I say targeting—they had indicated that using phrasing like, “protecting future generations” or tying it to the family unit as a whole was a good way to go, as far as showing the emphasis on how important these visits were.

Olivia Chan

Great, thank you so much. That is really great insight and learning, and really cool that you were all able to form partnerships like that. Sam, would you be able to flip to slide 17 so we can kind of see the interventions that Ashley was talking about? Perfect. Is there anything you want to add, Ashley?

Ashley Lauing

Well, I was just to say that that really did trigger that conversation that we had with providers on the immunization only visits. Right. We kind of sat down with our providers too, and our medical director at

the time, and said, you know, “at what point would a zero to 15 month-old child need an immunization that wouldn't also call for a developmental screening or a vision/hearing, a well-child visit of any sort?” And they said, “well, there really isn't one.” So we just started with that information and started asking partners, “hey, if anyone calls and says my kiddo needs an immunization, can we just train that staff to book them for a full well-child visit?” And one of two things that happened. Either they needed their well-child visit or they didn't need their well-child visit. Lord knows our providers across the nation are short staffed and overwhelmed. It just put a little extra time on their calendar that was easily utilized by walk-in recipients or otherwise, if they truly only did need a vaccine or immunization.

Olivia Chan

Great. It's super interesting. In continuing with the culturally relevant conversation, Kathleen, can you tell us more about the Black Infant Health program and tell us a little bit more about your partnership with BIH and the milestone incentives that you all came up with?

Kathleen Dalziel

Sure. The plan actually takes no credit for the organization Black Infant Health. They're a community-focused organization and they're rooted in the community. They support African American birthing parents. And in the way that the health plan supports, it's to provide health education about the plan, health education about infant well visits, the importance of postpartum care, and creates an environment for the Black Infant Health community to meet. We host their graduations and we provide them a comfortable place to convene.

We offer, again, those milestone incentives when they show up to their classes. They're given little nominal gifts, just something that makes them feel good about being there. Not that they don't already, but just to encourage future participation. I think Arlene may have a little bit more information on the Black Infant Health as well. But really, it's just to support them in what they already do, and to let them know we're aligned as a health plan with their goals, which is increased wellness and trust in the health care system and support. As somebody well said it, we sit back and we watch them do their great work and let them know that we're aligned with them.

Arlene Silva

I just want to add—We are also partnering with our state Black Infant Health program because of the success that Health Plan San Joaquin has presented in terms of the outcomes for our infants. We're looking into also sustaining the intervention, which is similar to Health Plan San Joaquin. So Black Infant Health is established by the California Department of Public Health within California, and they have this program within limited areas within the counties. I can't remember how many of those are, but we're planning on scaling the intervention and also having this more sustainable.

Olivia Chan

Great. Thank you so much, Kathleen and Arlene, for discussing more about that. We have one question also—I think you alluded to this. So the question is, is BIH statewide? If not, how do you plan to identify other community partners throughout the state?

Kathleen Dalziel

As Arlene mentioned, yes, there are some—not every county, but many counties have a branch of Black Infant Health. In other ways that we are engaging culturally relevant care, is through specific targeted

health education classes. So with that, we have, for example, some asthma classes that are provided by and supported by community-based organizations. We'll do the same with hypertension. So we're looking for community partners, partners that are entrenched in the community, to help us do our work. Hopefully that helps answer the question.

Olivia Chan

Great, thank you so much. All right. Thank you for all the questions that are coming through the chat. I think we have one question for Ashley or Sam. When South Dakota changed acute visits to preventive visits or did the billing, were the providers aware? And were both acute and preventive visits successfully billed at the same time? Or how did providers respond to that change idea?

Ashley Lauing

So we tracked it a couple of different ways, because, like I said, one of the biggest helps that we had with our claims lag is tracking on small scales. To start with, we use one of our providers that doesn't see a large amount of children to kind of track this. To start with, they would write down the Medicaid recipient ID of the child that had come in for an acute care visit. Then they tracked whether or not that recipient was then transitioned to a wellness visit. If not, why? Because as any clinician on here will be able to tell you, it's not always clinically appropriate to take an acute care visit and do a well-child visit along with it for a multitude of reasons. So what we ended up finding out was, one, that those reasons were significantly more so than we thought as policy people. But also they were able to—we provided billing guidance on that. I believe we sent out a provider listserv in general that I could try and get over to you, Olivia, that you could disperse if everybody else would like it. But we just provided billing guidance on how to bill for both encounters on the same day and what claims forms to use and just how to go about accomplishing that essentially.

Olivia Chan

Thanks so much, Ashley. Great. I have one question for Dorian. So you mentioned that your plan made calls to parents. So how many calls were made in order to collect the learnings about barriers?

Dorian Roberts

Wow, that's a great question. I can't remember off the top of my head right now, but I know it was over 100 calls were made.

Olivia Chan

Wow, that's quite a feat, but some great learnings that you all got from that. All right. This is a question for Arlene or anyone from California. So in California, will the Newborn Hospital Gateway help to resolve the issue of capturing newborn visits, which are being billed under mom's possibly commercial plan during the enrollment process?

Arlene Silva

Yes. We're hoping that this policy will be able to capture, as early as possible, our newborn babies, because right now, all our health plans are reconciling those. And sometimes there's a delay in the confirmation. Also, our moms also have to report it to the county, to their county eligibility worker as well. So we're trying to find a solution in order for us to capture the data as soon as possible. In order to

do that, our providers have to report new births within a 24-hour period, or 72. I can't remember what the policy is, but we can provide you the link. That should expedite the data.

Olivia Chan

Great. Thank you so much, Arlene. Best of luck for the implementation of that, and super exciting to see that policy. All right. I think we have time for one more question. So this is a question for South Dakota. Can you give an example of how you tested on a small scale to allow you to track more immediate results?

Ashley Lauing

Oh, gosh. Like I had mentioned with the previous one, with the immunization well-child visits, that was a clinic we had just kind of asked them to do this and then send us weekly information. Again, being a smaller clinic, they had the flexibility and the administrative staff to do that. When it came to our rack cards, the same kind of concept took hold. We asked them to write down each recipient that they had given the rack card to. We'd asked them to keep it to one provider so that we could track it a lot easier, just to start with. Again, these are all recommendations that Mathematica and CMS had for us because we were like, full send, let's launch it.

So we scaled a lot of stuff back and just took those recipient IDs. Then we're able with our data team to really be able to dive right into each recipient and see, did they make that next visit? And we could compare it to the population as a whole. Did we have a higher percentage in this group to the population as a whole? Or we could compare it to just—did it impact within the same group? Right. So those who got it from that clinic, were they more likely to come back in than those who didn't, just based on those smaller numbers? Which, in fact, we did find out through using that small scale testing that, yes—providing that tangible piece of literature and having the provider, not just the nurse or a clinical assistant, but having the actual provider go through that card and provide patient education with them—we tracked those, we did see an increase in attendance to appointments for those who received that tangible rack card versus those who did not. It led to us again doing provider communications that, you know, hey, we have these great tools to use. Then we sent them out to providers and to our pediatricians. I think we did like our top—and Sam, you can correct me if I'm wrong—but I think we did our top 15, 20 pediatric facilities that we sent them out to as a start.

Olivia Chan

Great. Thank you so much, Ashley, for sharing all that.

Ashley Lauing

Yeah.

Olivia Chan

Great. I think we are ready to wrap. So maybe we can go to our wrap up slides with QI TA resources.

Slide 41

Great. On Medicaid.gov, there's a range of QI tools to help develop and implement your own QI projects for a range of health topics. Materials from the Infant Well-Child Visits Affinity group have been posted as well. But stay tuned for the posting of today's slides and recordings. To request one-on-one support, you can email MedicaidCHIPQI@cms.hhs.gov. Next slide.

Slide 42

You can also brush up on your QI skills through courses from the MAC QI Open School by submitting an expression of interest form using this link. You'll have access to courses that help you apply the Model for Improvement and resources from the Institute for Healthcare Improvement's extensive library. If you have any questions, you can email us as well. Next slide.

Slide 43

You can also attend MAC QI Office Hours where you can drop in and bring your QI questions to an improvement advisor and a member of the CMS team. Please email us to join the distribution list to learn more about upcoming office hours. Next slide.

Slide 44

That wraps up our webinar for today. Thank you all so much to our speakers and to our participants for attending this webinar. Please complete the survey that will pop up as you exit the event. To learn more, you can contact CMS at MedicaidCHIPQI@cms.hhs.gov. I hope everyone has a great day.