CMS Affinity Group State Spotlights: Improving Postpartum Care

Wednesday, May 17th, 2023, 2:00 – 3:00 PM ET

Kristen Zycherman, CMS

Lekisha Daniel-Robinson, Mathematica

Gloria Beecher, DNP, RN, CPHQ, Georgia Department of Community Health

Patricia W. Witherspoon, MD FAAFP, South Carolina Medicaid and SC Birth Outcome Initiative

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Technical Instructions

Welcome to the CMS State Spotlights in Improving Postpartum Care 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

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Agenda

- CMS Introduction
- Improving Postpartum Care Affinity Group
- State Spotlights
  - Improving Postpartum Care in Georgia
  - South Carolina Maternal Care: Postpartum Care
- Questions & Discussion
- Upcoming CMCS Quality Improvement TA Opportunities

CMS Introduction

Kristen Zycherman, Centers for Medicare and Medicaid Services

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality
Measurement & Improvement

CMCS Quality Improvement Technical Assistance Program

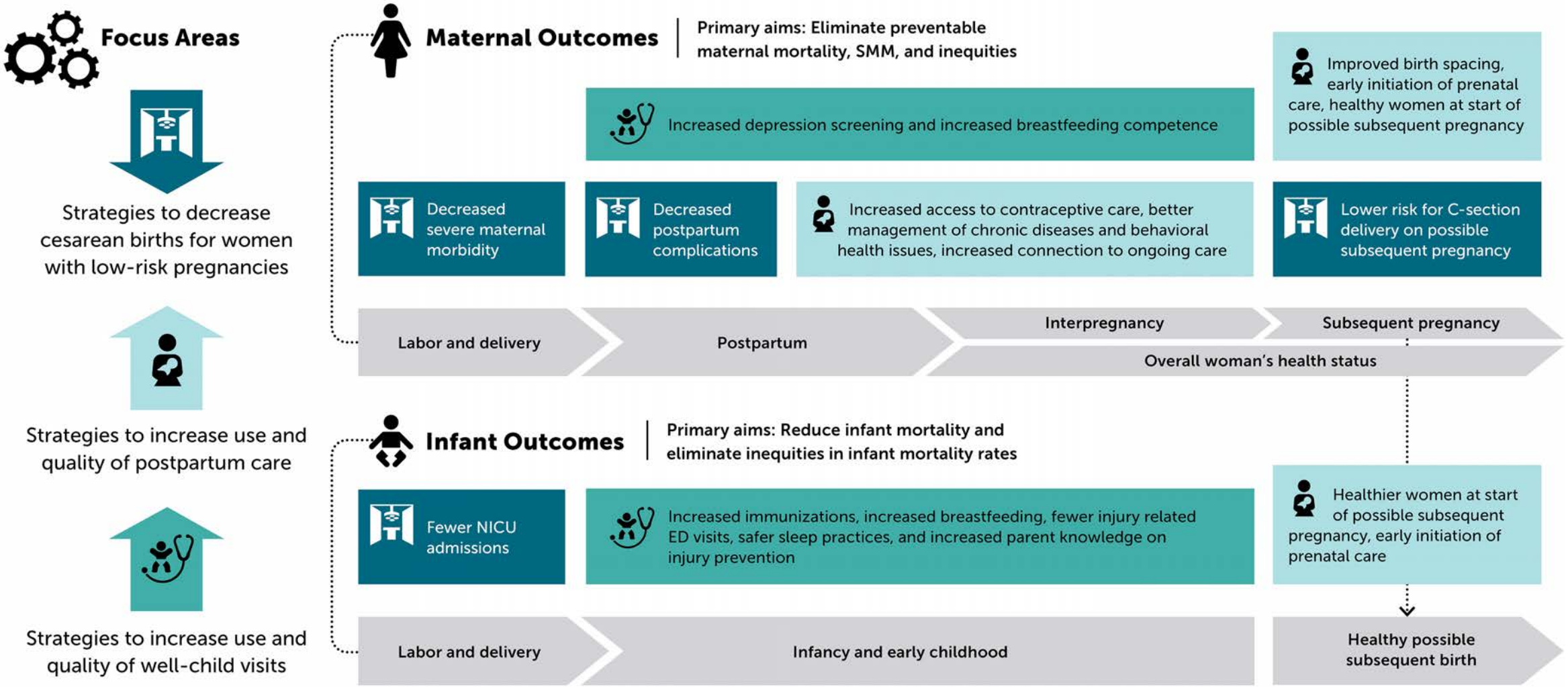
- The CMCS QI TA program supports state Medicaid and Children's Health Insurance Program (CHIP) programs and their QI partners with information, tools, and expert knowledge to improve care and outcomes for Medicaid and CHIP beneficiaries
- As part of the QI TA program, CMCS convenes action-oriented affinity 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

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Focus Areas to Improve Maternal and Infant Health Quality

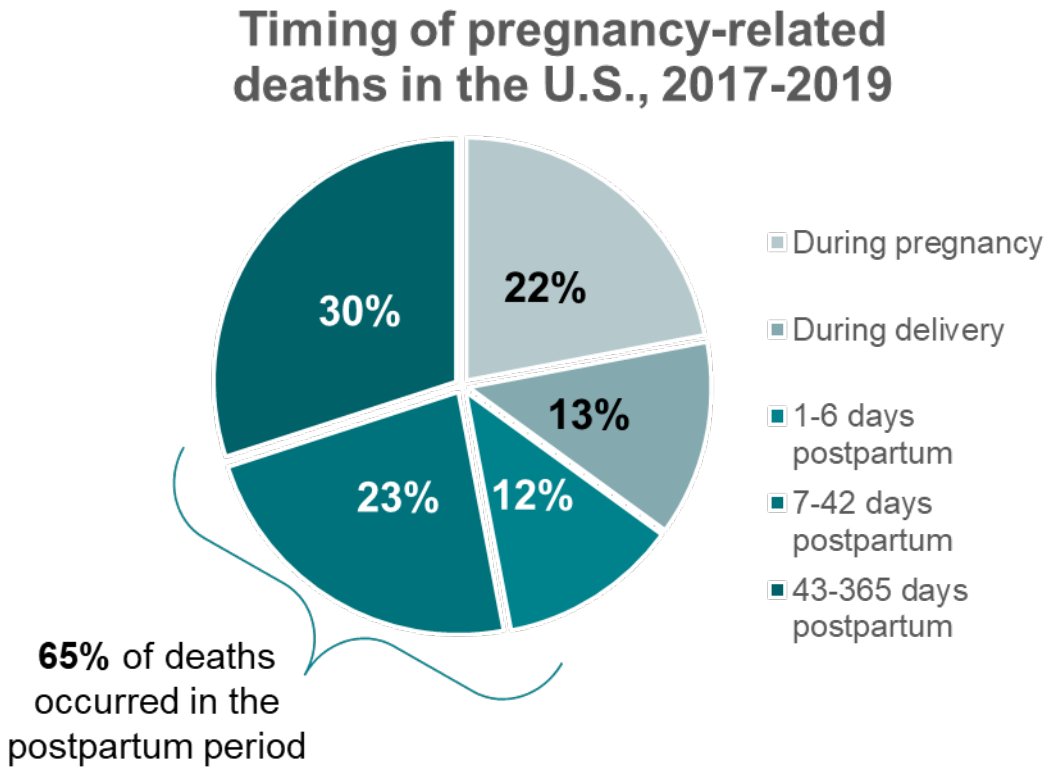


C-section = cesarean section; ED = emergency department; NICU = neonatal intensive care unit; SMM = severe maternal morbidity

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Why Focus on Postpartum Care?

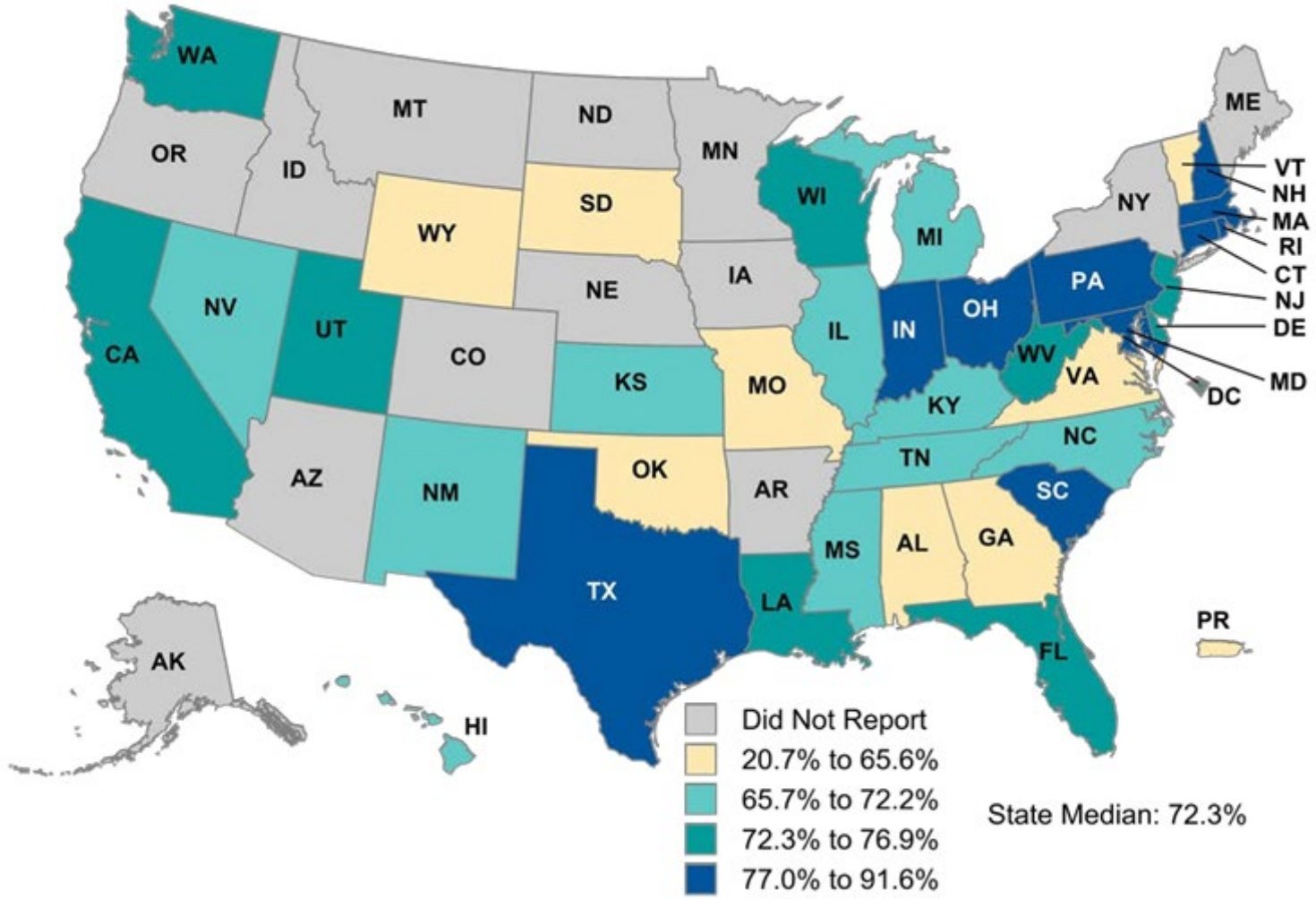
- Opportunity to improve maternal health outcomes and to intervene on disparities
- Alignment with American College of Obstetricians and Gynecologists guidelines on postpartum care
- Potential impact on pregnancy-related deaths and opportunity to address leading causes of death that occur after six weeks postpartum
- Potential to improve postpartum follow-up for individuals with mental health, diabetes, hypertension, cardiovascular and other conditions
- Disparities in pregnancy-related deaths, visit rates for hypertension and diabetes, and postpartum depression



Source: Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022. Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCs-2017-2019-H.pdf

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Percentage of Women Delivering a Live Birth who had a Postpartum Care Visit on or Between 7 and 84 Days after Delivery, FFY 2020 (n = 39 states)



Source: Mathematica analysis of MACPro reports for the FFY 2020 reporting cycle as of June 18, 2021.

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Improving Postpartum Care Affinity Group

Lekisha Daniel-Robinson, Mathematica

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality
Measurement & Improvement

Improving Postpartum Care Affinity Group Overview

- **April 2021 – April 2023**
- 9 participating states
- Action-oriented affinity group that supported Medicaid and CHIP programs and their partners in the design and implementation of data-driven postpartum care quality improvement projects

Affinity Group State Highlights

Georgia

Sought to improve postpartum health outcomes for women in rural Georgia

Engaged three care management organizations for regional diversity that conducted individual improvement projects

Kansas

Sought to increase the quality, quantity, and timing of postpartum visits in Black and Latinx beneficiaries in certain counties within the state

Partnered with managed care and community-based organizations to improve care; March of Dimes designed a postpartum experience of care survey which was fielded by partners; Interventions included home visiting, CHWs and doulas to coordinate care and SDOH needs

Kentucky

Sought to increase the postpartum care visit rate for Medicaid members

Implemented a multipronged strategy including the development of a maternal health dashboard and the use of doula care in partnership with managed care entities; culminated with plans for a statewide convening to deepen commitments and expand partnerships and programs to enhance service delivery

Affinity Group State Highlights (continued)

Missouri

Sought to increase the postpartum visit rates for beneficiaries with behavioral health or chronic health conditions in the Bootheel region and St. Louis region

Implemented a person-centered care coordination model to connect with beneficiaries with care, resulting in improved no-show rates in a large maternal fetal medicine clinic in the Bootheel region; working to spread the strategy to a Federally Qualified Health Center

Montana

Sought to increase attendance to postpartum visits in Big Horn county and improve the communication between various community organizations around the postpartum visit

Focused initially on outreach materials to beneficiaries/families, including a 3-minute video for waiting room; restarted a public health workgroup to promote breastfeeding and other postpartum-related topics; planned the development of a statewide maternal mental health taskforce

Oklahoma

Sought to identify improvement strategies, while focusing on delivery system reform to managed care with a strong quality improvement program

Conducted mortality and morbidity analysis resulting in the development of a program for high-risk members with cardiomyopathy; case management services initiated prenatally before transitioning to the chronic care management during the postpartum period; Medicaid staff conducting outreach to providers to increase awareness of the program and referral process

Affinity Group State Highlights (continued)

South Carolina

Focused on improving postpartum visit rates and quality particularly for beneficiaries with chronic conditions

Reviewed policies and internal processes for eligibility, enrollment, and MCO engagement; conducted doula intervention to understand engagement and SBIRT screening, and test of diabetes management approach that increased postpartum visits

Texas

Focused on improvements for Medicaid and CHIP beneficiaries who have hypertension

Established partnerships with and provided quality improvement coaching to MCOs for interventions to increase case management utilization; MCOs conducted individual improvement projects that included the use of doula care, dissemination of blood pressure cuffs, beneficiary education, and an app targeted to at-risk beneficiaries

Wyoming

Focused on increasing care management and postpartum visits for high-risk pregnancies to improve identification of maternal morbidity in the postpartum period

Conducted provider education on Medicaid care management benefits and tested web-based referrals to the care management program; explored the establishment of maternal medical homes within birthing hospitals

Improving Postpartum Care in Georgia

Georgia Department of Community Health

Gloria Beecher, DNP, RN, CPHQ *Director, Population Health & Quality Planning*
Hermann Ettien, *QPI Manager* **Dominic Molin**, *QPI Specialist* **Nicole Hodge,** *QPI Specialist*

Georgia Department of Community Health

Medicaid.gov
Keeping America Healthy

Mathematica®
Progress Together

Amerigroup RealSolutions in healthcare

peach state health plan

CareSource

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Background

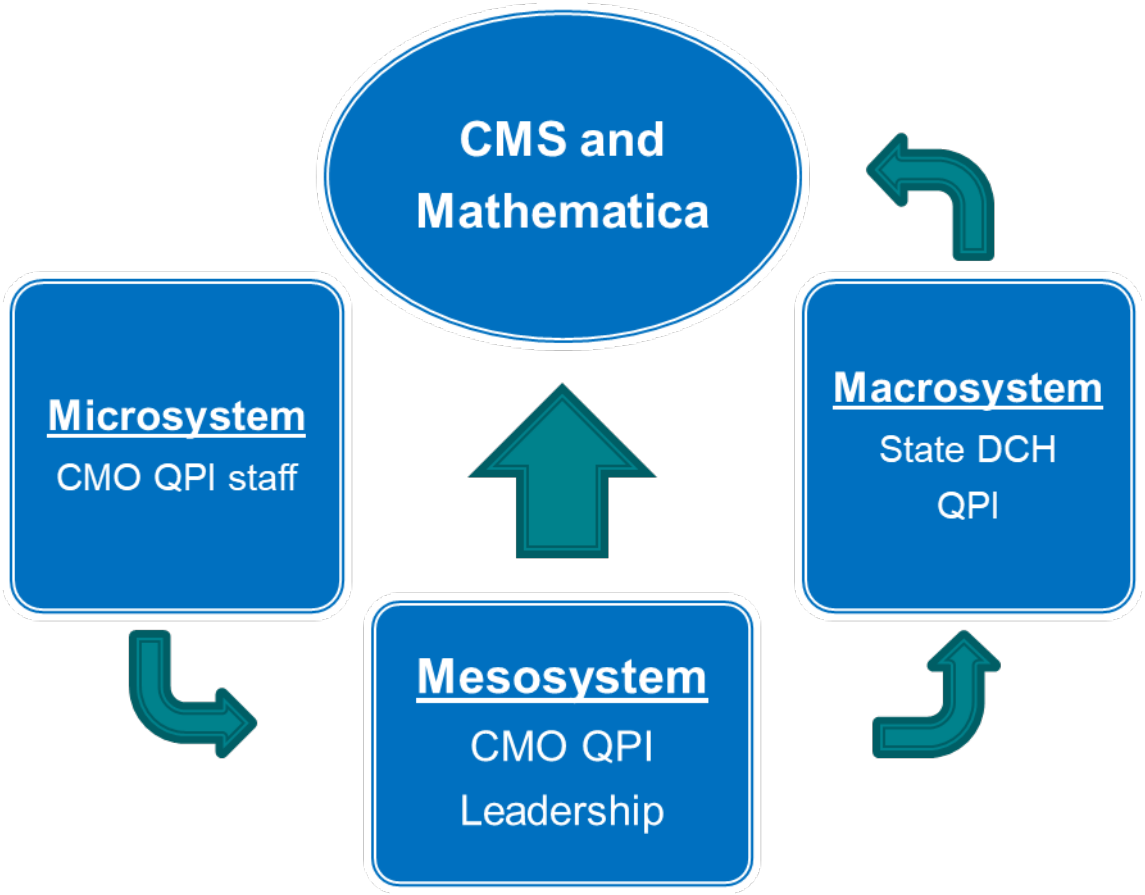
Beginning Steps

Start
- CMS announced AG
- State GA expressed interest & accepted to participate

Recruitment
- Extended invitations to Care Management Organization (CMO) and community partners
- Expression of interest and agreement to participate

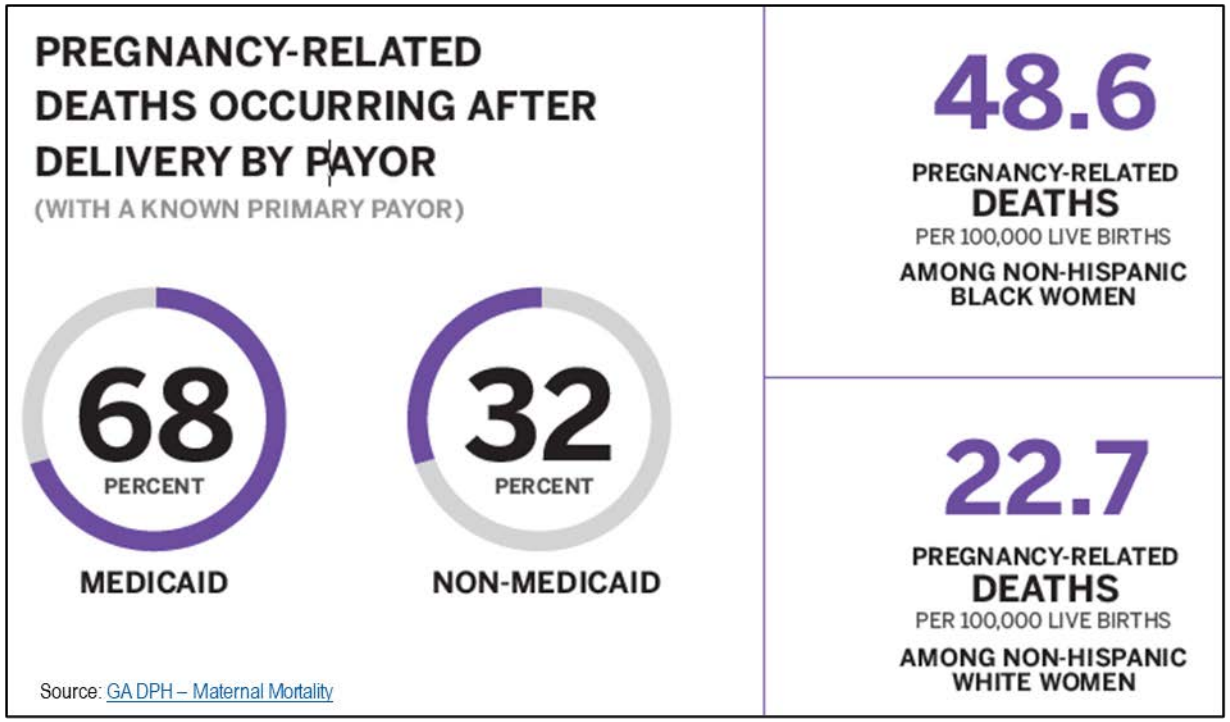
Kick-off
- Had working session, brainstorming for topic/aim
- Consensus reached on topic/aim

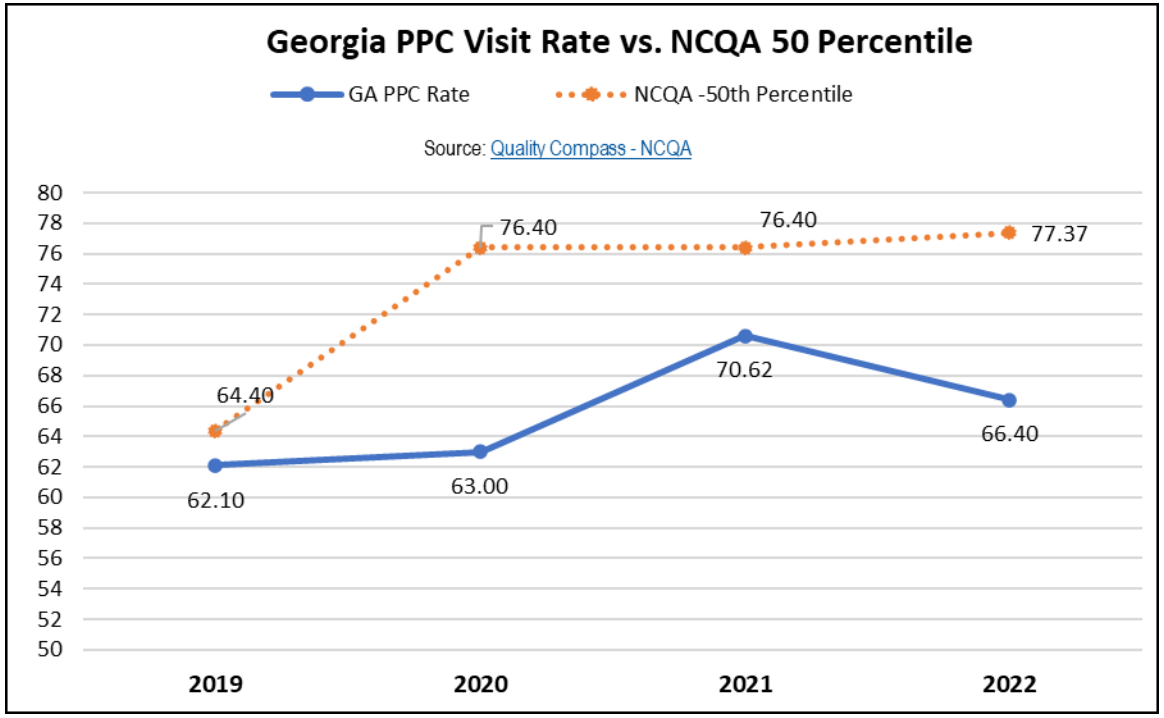
Teams & Workflow



Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

State of Maternal Health in Georgia





The Leading Causes of Pregnancy-Related Deaths

- Hemorrhage
- Mental Health conditions*
- Cardiomyopathy
- Cardiovascular / Coronary conditions
- Embolism
- Pre-eclampsia

- **Pregnancy-related death**—Death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy
- ***Mental Health Conditions**: Deaths where the underlying cause of death was depressive disorder, anxiety disorder (including post-traumatic stress disorder), bipolar disorder, psychotic disorder, substance use disorder, or another psychiatric condition not otherwise specified.

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Source: Georgia 2018-2020 Material Mortality

AG Project Aim Statement

The Challenge

Based on locally-available data and HEDIS-informed performance rates, Georgia has a significant opportunity to improve maternal care—specifically, increase postpartum visit rates and decrease maternal mortality.

Our Aim

Year 1: Increase Postpartum Visits Rates in Rural Georgia

Year 2: Improve Maternal Care in Georgia

Strategy

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Year 1 (April 2021—March 2022)

Objective: Increase Postpartum Visits Rate Rural Georgia

Three tests of change were done

Tests

- **Test 1**: gift cards to mothers who make and keep PPC appts
- **Test 2**: educational sessions for providers to enhance practice and billing
- **Test 3**: check-in with recently delivered members for appt or feedback on PPC visit

Outcomes

- **Test 1**: 7 women targeted- unable to contact 3, 2 attended appt, 2 made no appt
- **Test 2**: 2 sessions with 1 provider- test paused due to loss of OB educator
- **Test 3**: 1 contact made- member had attended appointment, reported her OB helped to set up appointment; unable to reach other members

Year 1 (April 2021—March 2022)

Objective: Increase Postpartum Visits Rate Rural Georgia.

Impact of tests of change

Barriers

- Staffing shortage related to pandemic
- Challenges in tracking members, no phone, no alternate contact information
- Weekend delivery/discharge
- Challenges with global billing
- Lack of billing knowledge

Lessons Learned

- Strong message - Provider and member engagement are vital for PI in PPC
- Claims data mismatch for PDSA
- Need to get secondary/alternate contact for member during course of pregnancy/at delivery
- Schedule PPC visit prior to discharge

Year 2: Pivot & Relaunch (April 2022-April 2023)

- **Response** (End of Year 1)

  Mixed response to PDSA cycles
  - Waning interest with small scale tests, slow progress
  - Incomplete/abandoned tests
  - High interest to continue, maybe start all over
- **Resolution**

  State adopted practice from Texas Medicaid to ramp up CMO engagement
  - Talked one on one with CMOs to assess interest and explore way forward
  - Allowed CMOs to choose their own aim, population and region
  - Had CMOs do one-on-one meetings with Mathematica
  - Extra step: State PI team provided TA calls in-between meetings with Mathematica
- **Relaunched**
  - With 2 CMOs –QPI leaders and their team
  - Third CMO joined a few months post relaunch
  - Continued two-pronged approach – provider and member

Year 2 | Test 1

IMPACT OF PROVIDING PROVIDER INCENTIVE INFORMATION & SUPPORT

Test

If providers are given incentive information and a list of members needing postpartum visit, would it increase PPC visits as evidenced by increase of claims for postpartum visit?

Outcome

1st Cycle

Included 9 providers and saw almost 1% increase in PPC visit claims.

2nd Cycle

Scaled to 20 providers < 50% participated – claims data pending

Next Step

Re-test using Subject Matter Experts to engage providers

Year 2 | Test 2

Exploring Provider Support to Increase PPC Visit Rates

Test

Does offering providers coding education and/or incentive result in increasing PPC visit rates?

Three regions included in test

- Region 1: coding and incentive information presented in-person and flyer
- Region 2: incentive information only, presented by flyer
- Region 3: coding education only, in-person presentation

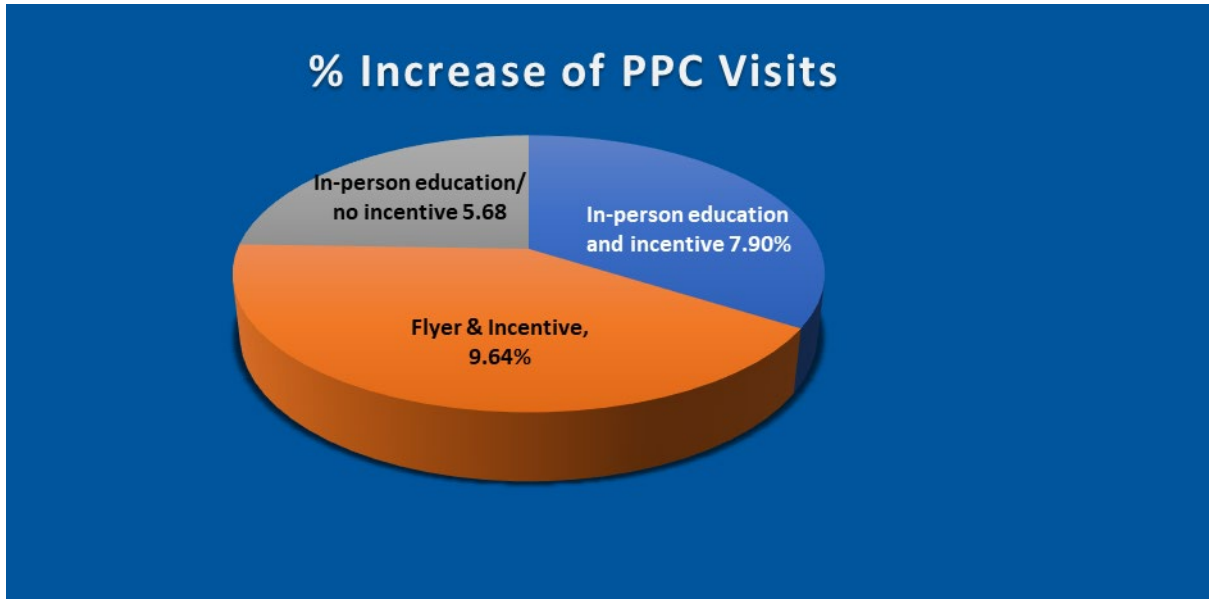
Outcome

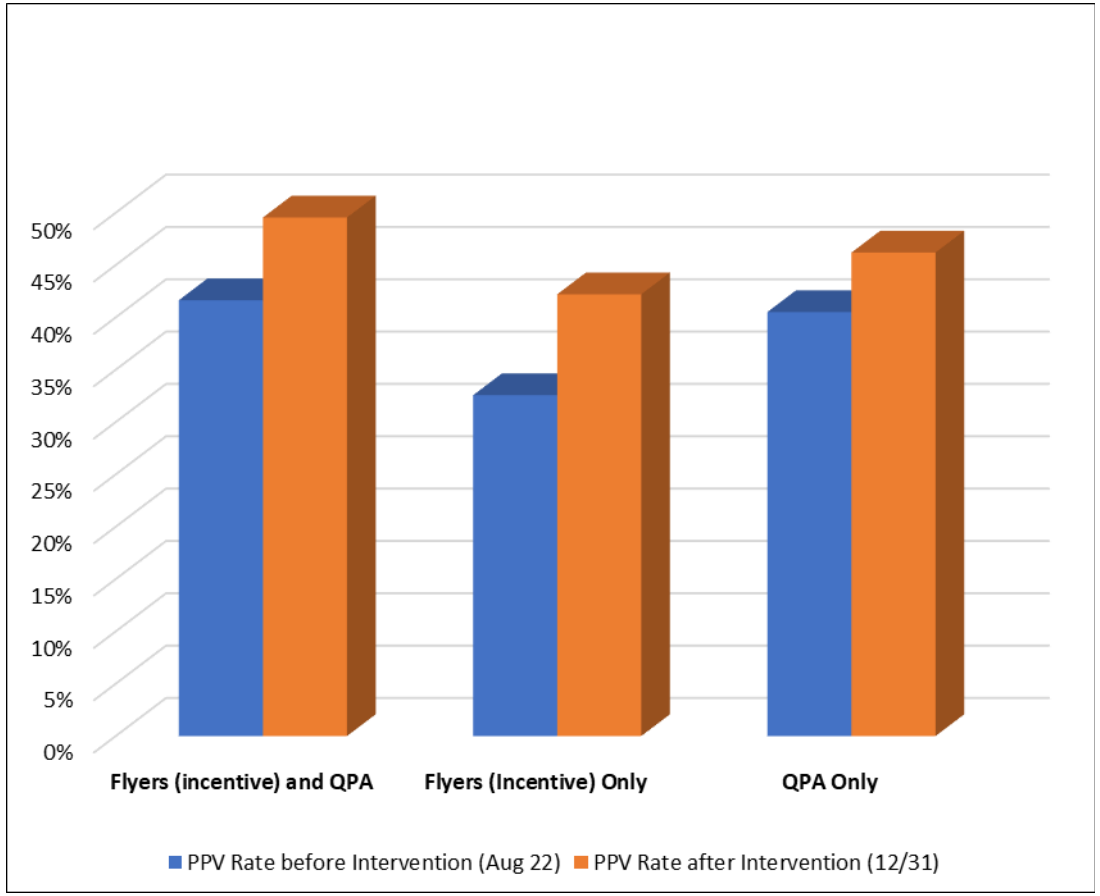
- Coding education without incentive was least effective
- In-person education and incentive was close to most effective
- Flyer and incentive most effective

Year 2 | Test 2 — Data

Test 2: Using coding education and incentive to increase PPC Visits rates.

Postpartum Care Visit Performance				
Region	**Support Type**	**PPV Rate before Intervention (08/22)**	**PPV Rate after Intervention (12/31)**	**% Increase / Decrease**
1	Flyers (incentive) & in-person education	41.64%	49.54%	7.90%
2	Flyers (incentive) only	32.56%	42.20%	9.64%
3	In-person education only	40.51%	46.19%	5.68%





QPA = in-person education

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Year 2 | Test 3

Blood Pressure monitoring in postpartum women

Test

Will postpartum women with DX of hypertension or a related condition, self-monitor if provided with blood pressure (BP) monitoring device

Outcome

- 1st Cycle: included one mother. Met goal of checking BP once weekly for 4 weeks.
- 2nd Cycle: Scaled to 4 women – 1 mom measured 4 out of 4 week, another 3 out of 4 weeks, unable to reach (UTR) 2
- Women who met goal required prompting/reminders to check and record their BP
- Record review showed UTR women refilled BP meds and had PPC visit

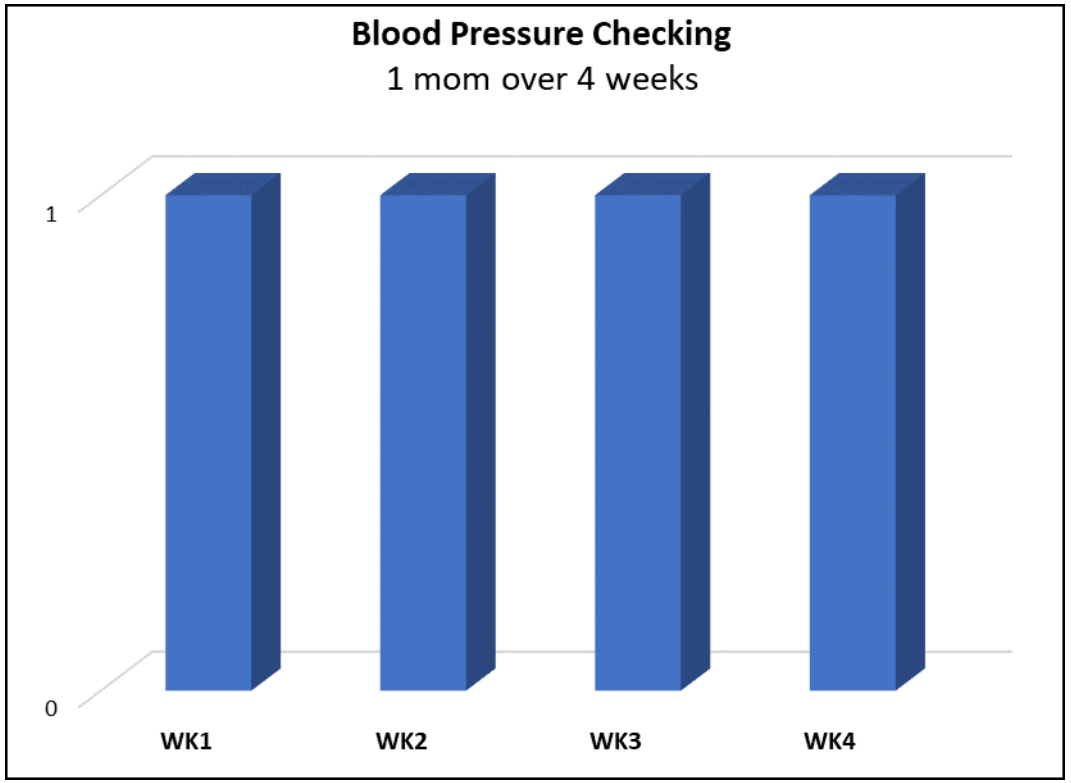
Next steps

Scale with plan to adopt provision of BP monitors to PPC women

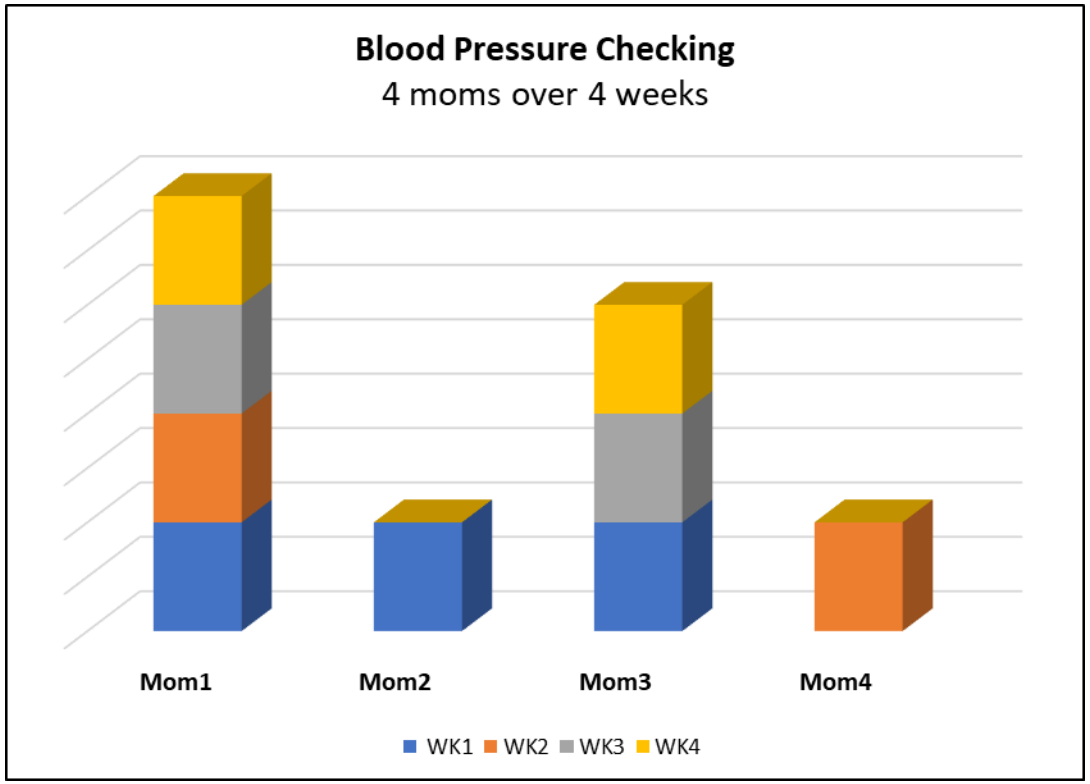
Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Year 2 | Test 3 — Data

Test 3: BP Monitoring Post Delivery



***Cycle 1**: One Member*



Cycle 2: Scaled up to 4 Members

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

YEAR 2: REFLECTIONS

Barriers

- Engaging enough providers to scale up tests
- Use of claims-based data for Rapid Cycle
- Members dependent on prompts to check BP
- Unable to reach members for BP monitoring
- Members not adhering to home monitoring of BP

Lessons Learned

- Allowing CMOs greater flexibility and support, builds trust and leads to greater engagement, and positive partnership
- Conducting consistent check-ins with members, builds trust and leads to greater adherence to care
- Providing incentives and education to providers may be helpful to increase PPC visit rates

Emerging Themes

- Need for screening/management of behavioral health in postpartum members
- Need for addressing Social Determinants of Health, especially childcare needs and transportation
- Need to educate members during prenatal care of the benefits of postpartum care

Spread and Sustainability

Spread

Some promising outcomes that can be adapted and or ready for spread include:

- Providing coding education and incentives to providers to drive PPC visit rates
- Providing blood pressure monitors to pregnant/postpartum women
- Coaching/supporting members with monitoring blood pressure

The State will continue to partner with CMOs to adjust and scale up these tests

Projection and Sustainability

With continued engagement of CMOs, and support from the State, CMOs will work to adopt these as maternal care practices statewide

South Carolina Maternal Care: Postpartum Care

Patricia W Witherspoon, MD, FAAFP, South Carolina

Co-Chair Access and Coordination subcommittee

SC Birth Outcomes Initiative

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality
Measurement & Improvement

Background: South Carolina

- SC DHHS pays for over 60% of all deliveries for the state
- In SFY 2020, less than 70% of women enrolled in Medicaid have a postpartum care visit
- Adequate postpartum care is essential to ensure the physical and emotional wellbeing of the mother and the newborn
- Timely postpartum care can avoid unnecessary complications by addressing care of chronic conditions and mental health needs
- Documented geographical pattern between low postpartum care visits and high low birth weight babies
- Statistical association between low postpartum care and high rates of severe maternal mortality

AG Project Aim Statement

The Challenge

- Lack of cross communication of successful and unsuccessful programs within the state
- Lack of uptake of screening tools (SBIRT) and programs provided by MCO (case management, health coaches)
- Geographic makeup of the state (rural vs urban); unique issues in rural parts of the state; hospital closures and lack of OB practices
- Poor access to reliable transportation

Our Aim

By year end 2026, SC Medicaid aims to improve the postpartum visit (PPV) rate by 15% (from 2019 statewide base line of 67% to 82%) and to improve PPV quality. MCOs will adhere to ACOG guidelines for PPV and follow-up, focusing on women with chronic conditions such as hypertension, diabetes, cardiovascular disease, obesity, substance use, and depression. There will be a specific effort to mitigate the state's health inequities.

Strategy

- Improve communications between agencies, providers and beneficiaries
- Identify successful programs and practices
- Replication and spread

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Strategies and Interventions

- **SC DHHS Bureau of Quality: Community Initiative**
- **Funding the 2nd year of a CHW pilot with emphasis of Perinatal Care and Diabetes**
  - The first year of pilot has already shown improved engagement with mom and the providers.
- **In a specific program, Diabetic Mom's (Diabetes Free SC), moms showed high rates of postpartum visits.**
  - They are looking at how to spread this model to areas that are resource poor.

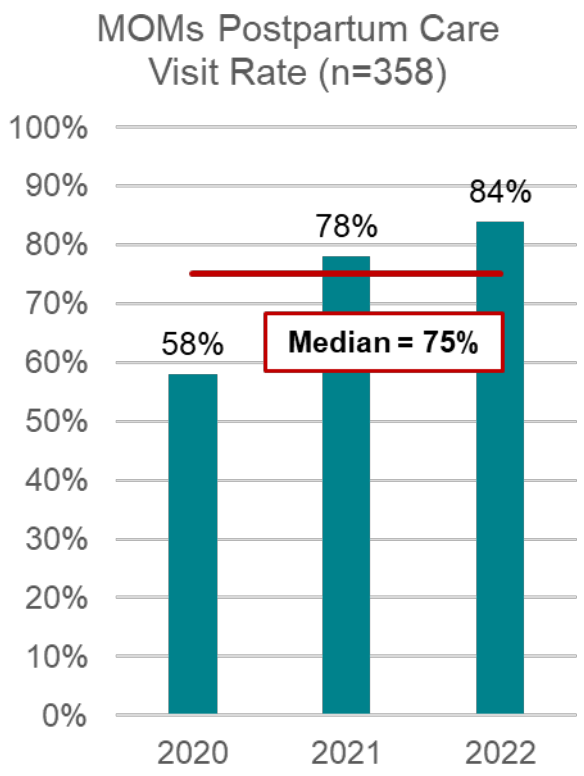
Strategies and Interventions (continued)

- **SC Birth Outcome Initiative (SCBOI)**
  - Alignment of Mesosystem with SCBOI Vision team
  - SimCOACH: reopening the mobile unit for instructing hospital systems on best maternal practices. Hands-on teaching tool. Past curriculums include Postpartum Hemorrhage, Sepsis, and Shoulder Dystocia, etc.
- **Continue to participate in Alliance for Innovation on Maternal Health (AIM)**
- **SC Maternal Morbidity and Mortality Review Committee 2023 Legislative Brief:**
  - Leading cause of pregnancy-related death: cardiomyopathy
  - AIM Bundle: Cardiac Conditions in Obstetrical Care

Diabetes Free SC: Management of Maternal (MOMs) Program

- Blue Cross Blue Shield Foundation operates the MOMs program to serve pre-pregnancy, pregnant, and postpartum mothers with diabetes.
- Since 2019, the MOMs program has included about 1,000 pregnant participants in three centers across the state.
- The program offers patient education and materials to support diabetes and hypertension care, food and hygiene supplies, mental health screenings, and telehealth care.

MOMs Program: Measures and Data



- **Overall, 75% of postpartum MOMs participants attended at least one postpartum visit, with rates increasing each year**
- **Disparities were observed…**
  - ***By diabetes type***: Type 1 and Type 2 diabetics exhibited higher postpartum care visit rates (83% and 80%, respectively) compared to participants with gestational diabetes (68%)
  - ***By race and ethnicity***: Hispanic participants had higher postpartum care visits rates (83%) than their white (73%) and black (71%) counterparts

Data provided by Diabetes Free SC

MOMs Program: Measures and Data (continued)

- **89% of patients' A1c levels at their most recent reading were controlled below 6.5% or decreased by at least 5% since their last enrollment**
- **Patients with gestational diabetes had higher rates of targeted A1c levels (97% controlled), compared to Type 1 (75%) and Type 2 (84%) diabetics**
- **Additional measures were tracked to inform program efforts, including:**
  - Demographics (maternal age, BMI, marital status, language, insurance)
  - Gestational weight gain at delivery
  - Provision of services and supplies (e.g., # of food bags distributed)
  - Percentage of patients receiving telehealth
  - Infant outcomes (birth weight, timing of deliveries, Apgar scores, NICU admission rates)

BirthMatters

- BirthMatters is a community-based organization that provides free doula services to young expectant birthing people (under 25 years old) until the infant is 12 months old
- BirthMatters conducted a PDSA cycle to identify best practices for doula engagement in postpartum care access. Five moms who delivered in 2020 were interviewed

BirthMatters: Measures and Data

- **All moms…**
  - reported that their doula supported them during their postpartum experience and ensured attendance at appointments
  - reported feeling like their provider listened to their concerns and allowed time for questions
  - reported discussing sexual health and contraceptive decisions with providers.
- **Varying levels of adherence to other health promotion behaviors**
  - 1 of 5 reported checking c-section scars
  - 1 of 5 reported assessing healing from tears
  - 2 of 5 reported checking blood pressure
- **2 moms reported mental health challenges but were not assessed for behavioral health needs at their postpartum visits. They were connected to therapy through the BM program.**
- **2 of 5 moms were aware of Medicaid expansion, while 3 of 5 were not and said they would have liked to have been informed about Medicaid expansion.**

Spread and Sustainability

- **Two PDSAs led to national funding for sustainability**
- Creating the environment for shared expertise via the Postpartum Learning collaborative resulted in (2) Competitive grant submissions accepted via Patient-Centered Outcomes Research Institute (PCORI)
  - Doula
  - Listening to Women via texting platform for moms
- Creating a reliable method to communicate with plans, providers and beneficiaries
- **Clarifying existing policy in the SCDHHS Provider Manual**
- Using SCBOI Subcommittee Access and Care Coordination Workgroup to share ideas with SC Diabetes Free, MCOs and grass root organizations and Community Based Organizations (CBO)

Spread and Sustainability (continued)

- *Improving Postpartum Care for Black Pregnant and Postpartum People*

  The long-term goal of this research is to reduce maternal morbidity and mortality associated with undetected and untreated early postpartum complications, particularly for low-income, rural and minority populations. The objective of this project is to determine the effectiveness of **Listening to Women and Pregnant and Postpartum People intervention** compared to the **Standard Of Care** in reducing the need for **emergency department** visits for neglected or unnecessarily escalated postpartum complications and improving patient-centered **patient-reported outcomes** at six weeks, and 3, 6, 9 and 12 months postpartum.

The PI of both studies are a part of the BOI subcommittee structures, and we will follow along results as we look at ways to extrapolate and spread.

Spread and Sustainability (continued)

The PI of both studies are a part of the BOI subcommittee structures, and we will follow along results as we look at ways to extrapolate and spread.

- *Implementing Doula Care in Medicaid to Advance Racial Equity in Severe Maternal Morbidity*
  - Assess implementation of new state Medicaid doula programs, including efforts focused on racial health equity and Medicaid beneficiary experience of connecting with and using doula care in the postpartum period
  - Evaluate the extent to which doula care facilitates equity in the quality of postpartum care, postpartum treatment for chronic conditions (cardiovascular and mental health/substance use disorders) and experiences of postpartum care
  - Estimate the effects of state Medicaid doula care programs on racial equity in postpartum severe maternal morbidities

Reflections and Lessons Learned

- SCBOI is an incredible structure to work in; we were able to have numerous stakeholders at the table
- We have a very enthusiastic core of thought leaders that are very invested improving maternal and infant care
- We have several stakeholders working individually on the complex maternal and infant health issues
  - SC DHHS, Department Health Environmental Control, Family Solutions, Birth Matters, Diabetes Free SC, FQHCs, Healthy Start, Medical University of South Carolina, hospital systems, USC, Rural and Minority Health Research Center, etc.
- **Data are crucial**

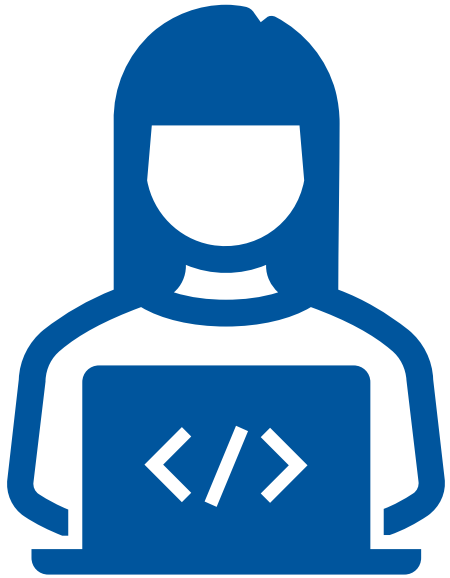
Reflections and Lessons Learned (continued)

- Change is slow and hard!!!
- Start small to garner some wins before attempting BIG Changes
  - We made assumptions and correcting severely delayed our movement forward
- Having good intentions doesn't always result in change
- **Know the goals and mission of the leadership structure first**
- MFI has been helpful in having conversations with stakeholders allowing them to see our process and point of their entry

Questions & Discussion

New! On-Demand QI TA

- **On Medicaid.gov**
  - QI tools to begin and implement QI projects
    - Driver diagram with evidence/experience-based change ideas
    - Measurement strategy
    - “Getting Started with QI” short video
    - Highlights from the AG
    - Previously presented topical webinars
  - Additional 1:1 support
    - MedicaidCHIPQI@cms.hhs.gov
- **Topics currently available**
  - Asthma
  - Tobacco Cessation
- **Topics under development**
  - Improvement Postpartum Care
  - Improving Fluoride Varnish in Primary Care
  - Managed Care QI TA
  - Improving Timely Health Care for Children and Youth in Foster Care
  - Improving Behavioral Health Follow-up Care
  - Improving Infant Well-child visits, 0-15 months

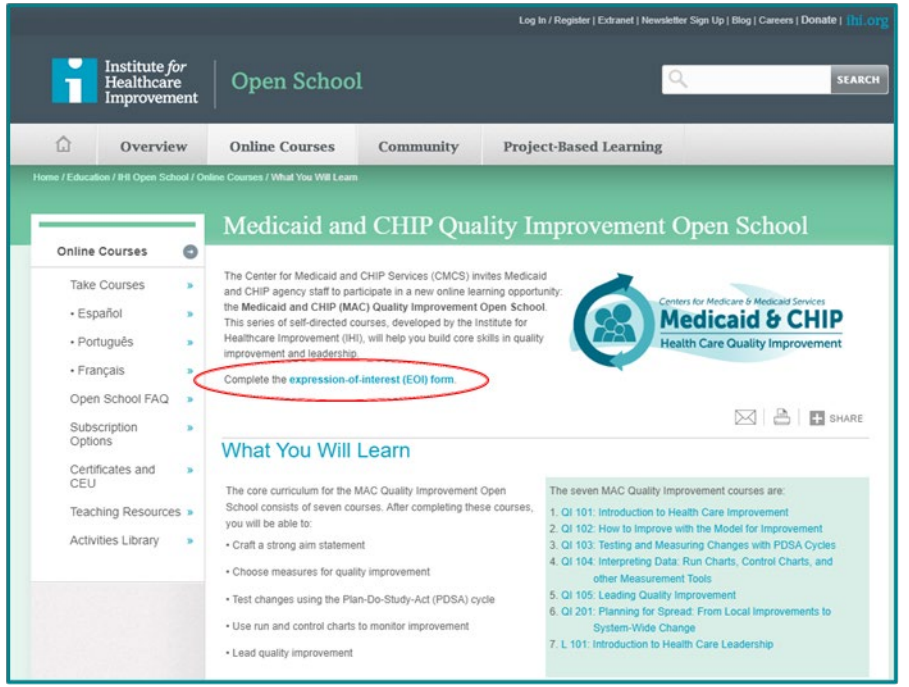


Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

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

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

MAC QI Office Hours

MAC QI Office Hours

- Offered **three times** every month with an Improvement Advisor
- Offered **once a month** with 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

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Thank you for participating in the webinar.

Please complete the survey as you exit the webinar.

To learn more, contact CMS at
MedicaidCHIPQI@cms.hhs.gov

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality
Measurement & Improvement