Webinar #5 Medicaid and CHIP Program Collaboration with Hospitals on AIM Bundles-20240820 1801-1_1

[Lekisha Daniel-Robinson] Hello and welcome, everyone, to the webinar, "Medicaid and CHIP Maternal Health Webinar Series: Collaboration with Hospitals on Alliance for Innovation on Maternal Health Bundles". During today's meeting, we will learn more about the Health Resources and Services Administration AIM Safety Bundles and then from Texas Medicaid to discuss partnerships between Medicaid and other partners to improve maternal care. We will follow with your questions for our panelists and discussion; and as noted earlier by Derek, you may submit your questions at any time during the presentation. I would now like to turn to Kristen Zycherman, Technical Director in the Center for Medicaid and CHIP Services.

[Kristen Zycherman] Thanks, Lekisha. On behalf of CMS, I want to welcome all of you who are joining us today. We're so pleased that so many of you are able to join us because you agree with us that this is such important work to be doing. I will give an overview of the objectives for today, which is to provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP programs. To describe the Health Resources and Services Administration's (HRSA) AIM safety bundles, and to review the Texas Department of Health Services Interagency collaboration on the use of AIM bundles. We're excited that our colleagues at HRSA are here to discuss the AIM bundle program as well as our colleagues from Texas Medicaid on how they are using them.

Just a little background that will be a rerun for those of you that have joined our previous webinars; but as a reminder, the Maternal Health Initiative launched in July 2014, and it is for the purpose of improving outcomes in Medicaid and Children's Health Insurance Program for pregnant people and infants in Medicaid and CHIP. The topics chosen for this point in the Maternal Infant Health Initiative that were covered in this webinar series -- maternal mental health and substance use, as well as maternal hypertension and cardiovascular health -- are leading drivers of maternal morbidity and mortality. It was very important to us to address these topics in MIHI, as well as through this webinar series, and then in the affinity groups which we'll be kicking off this fall, which we'll talk a little bit more about with upcoming information. With that, I will hand it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you so much, Kristen. To get us started and to understand *your* perspective on the collaboration within states, we've identified the three poll questions before you. I believe we're about to launch the poll window. You should see it in the lower right-hand corner of your screen. Hopefully you're able to find it. But again, we wanted to understand what your perspective on collaboration is within your states.

The first question: *"Is your state Medicaid and CHIP program actively supporting the implementation of the AIM bundles?"*. Question two: *"Is your state Medicaid and CHIP program regularly meeting and actively collaborating with Public Health on maternal health topics?"* Finally: *"Is your state Medicaid and CHIP program regularly meeting with and actively collaborating with Perinatal Quality collaboratives on maternal health topics?*

We have another minute for the poll before it closes, and we invite you to please participate in the poll. The presentation that we are expecting for today will hopefully provide some additional insight about opportunities for supporting AIM. We have about 30 more seconds; but I think we can perhaps close the poll a little early after five more seconds.

All right, and so our results in terms of the first question -- whether your state program is actively supporting implementation -- there are some "don't knows," mostly "don't knows" or no answer. For the second question, the active collaboration, we have some "Yes's," so that' good -- less "No's," that's great. Looks like 30% on the "Yes's." Finally, "*Is your state Medicaid and CHIP regularly connecting with PQCs*," and it's split between "Yes" and unsure.

Thank you for participating in the poll. We will circle back to some of these responses when we get to the discussion. For now, I would like to introduce our first speaker, Sarah Wright, a Public Health Analyst and AIM Capacity Program Lead at the Maternal and Child Health Bureau within HRSA.

[Sarah Wright] Good afternoon and thank you so much for allowing me to be here and be a part of this presentation. Again, my name is Sarah Wright. As Lekisha mentioned, I'm a public health analyst within the Maternal Health Branch Division of Healthy Start Services at HRSA, which is in our Maternal and Child Health Bureau. In addition to working directly with grantees under our AIM programs and some of our other programs, I am the lead for HRSA's Alliance for the Innovation of Maternal Health, which hopefully we're all sort of familiar with at least, commonly referred to as AIM. But for those who *are* less familiar with AIM, this program is the national cross-sector commitment and the quality improvement initiative designed to support best practices that ultimately make for safer, improved maternal health outcomes and saved lives. That's what we're all working towards through AIM.

To kick off this portion of today's presentation, I wanted to give a very quick background on the AIM program, how it was established, and how it has evolved over its 10-year history to sort of give you an idea of what AIM is grounded in and how it has sort of, like I mentioned, evolved, transitioned, improved, and grown over the years.

First, I would like to lay the foundation of where AIM as a program sits at the federal level. HRSA is often colloquially called a "grant-making organization." This is because the vast majority of our dollars go out the door due to grant and cooperative agreements. The grant fund aims to support the HRSA vision of healthy communities, healthy people, as well as our mission to improve health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs.

To realize this mission and vision of HRSA's, our Maternal and Child Health Bureau, where the AIM program sits, works to address, among many things, maternal mortality and severe maternal morbidity. To support MCHB's vision of an America where all mothers, children, and families thrive and reach their full potential, our strategic plan is centered on access, equity, capacity, and impact.

With that, MCHB is taking a multipronged approach to advance maternal health, developing and supporting federal grant programs that fall within HRSA's mission-critical areas of state systems and innovations, workforce and quality improvement, and direct support and services. You can see a wide variety of programs that fit under these umbrellas that AIM is also one such program funded by MCHB; and with AIM, it's really focusing on health care quality improvement so that we can address the leading known causes of maternal mortality and severe maternal morbidity in the U.S.

To dig into AIM more specifically and give you that picture of how it's evolved, this initiative actually began all the way back in 2011 when the American College of Obstetricians and Gynecologists, or ACOG, first convened the Council on Patient Safety in Women's Health Care. This was the predecessor to AIM. The Council first began the development of maternal health patient safety bundles, which then continued in the 2014s as the first AIM funding opportunity from HRSA; and that was ultimately awarded to ACOG.

While I will dive into the bundles in more detail in just a few slides, I did want to pause from our funding history for a moment to define what these patient safety bundles are, both for those less familiar with AIM and health care quality improvement and because these are such an important foundation of AIM. The AIM patient safety bundles are sets of actionable steps, usually ones that are kind of small that you build upon over time. They're intended to improve the quality of care that is provided during delivery and in the postpartum period. These actionable steps are informed by research and experts in the field and on-the-ground, in the hospital setting learning from working with patients. They include relevant best practices for each condition that they address; so that might include things like protocols, provider education, policies, preparation of medication and supplies, assessments, and many more things. So that’s a quick spectrum of bundles since this is the first time that we've mentioned them during this presentation.

Getting us back to a quick tour of the funding history, MCHB funded ACOG again after that first initial funding in 2014. The next funding cycle began in 2018, and it not only continued the development of

those patient safety bundles but it also kind of expanded into developing resources and providing technical assistance for the state-based teams that are the ones implementing bundles or moving the bundles into the birthing facilities within the state.

In 2022, Congress authorized a new unique legislative authority specifically for innovation in maternal health, which was reflective of our AIM programming. But as sometimes happens, additional funding was not initially appropriated for this legislative authority; it wasn't until 2023 that HRSA was able to develop a new funding approach for AIM. With this new approach, instead of ACOG and the AIM entities supporting states, it's now HRSA that directly funds currently 28 states including Puerto Rico and the District of Columbia, through what's known as our AIM Capacity Program. We also fund an AIM TA Center that was awarded to ACOG; and it also supports the state teams by providing technical assistance, developing resources, and doing coaching and direct support.

The AIM Capacity awardees at the state level range from universities and state health departments to hospital associations and even foundations. These agencies typically follow the state's perinatal quality collaborative, which is often the entity implementing AIM. With this new funding, HRSA was very intentional in acknowledging that each state varies in terms of AIM implementation. Some states started in AIM way sooner than others. Some states have had more support either at the legislative level or in terms of progress. With our acknowledgement that there are these variety of stages that states are at, the AIM Capacity Program is really meant to afford states the ability to pick and choose what their AIM needs are and identify a focus that was most appropriate for them.

For example, while some states are using their AIM Capacity funds to support bundle implementation or bundle sustainability, others are more focused on enhancing their data capacity for developing things like communities of learning or other educational opportunities. This flexibility, as I mentioned, was intentionally included within the Notice of Funding Opportunity to help us ensure that HRSA was meeting states where there are in their AIM journeys.

Beyond the specific AIM Capacity funding, we do also want to note that AIM's state or jurisdiction-level teams are in 49 states in the United States as well as the District of Columbia and Puerto Rico. These AIM programs all coordinate and support implementation of the patient safety bundles. We are anxiously awaiting, within the next couple of weeks -- so poor timing for this webinar, but it will be coming out soon. As of August 2023, that's our last datapoint, there were 1,996 birthing facilities across all 50 states, D.C., and Puerto Rico that were implementing AIM patient safety bundles.

In addition to the current AIM Capacity Program, as I mentioned before, we've also awarded ACOG to serve in this time frame as the AIM Technical Assistance Center. ACOG, as we noted in the timeline, has been critically involved in AIM since its inception and has been funded as the AIM organization since the first funding opportunity way back in 2014. While the funding to ACOG originally began with a focus on bundle development and supporting bundle implementation, it has really expanded over the years to include developing an extensive range of resources, technical assistance, and education, as well as a significant focus on gathering and analyzing AIM data from the states and then supporting the states as they gather that data and build their data capacity. As the AIM TA Center awardee, the AIM Team at ACOG provides comprehensive, high impact technical assistance to all the entities implementing AIM in the West, not just the HRSA-funded AIM Capacity awardees but all the states doing the work.

That was the background, which I think is really important to contextualize the AIM and the growth it's had over the past decade. Next, I'd like to provide, as promised, a little more background specifically on the AIM patient safety bundles themselves. As we highlighted earlier, AIM's maternal patient safety bundles are structured ways of improving the processes of care and patient outcomes. They have been developed to be descriptive rather than prescriptive for both the health care teams implementing the bundles and the state-based AIM teams that support the hospitals and birthing facilities so that they have options and flexibility as they implement the bundles.

The AIM bundles really bring together evidence-informed best practices developed by multidisciplinary expert consensus that addressed clinically-specific conditions in pregnant and postpartum people. I did want to pause before we go to the next slide because I just used the term "evidence-informed" to talk

about the bundles. I know that's not typically what we hear, so I kind of wanted to take a moment and explain. For AIM, "evidence-informed" means the bundles are these collections of activities and actions that are informed not just by research but also clinical expertise and lived experience. It is different from evidence-based practice because these evidence-informed bundles are enriched by previous research, but they aren't necessarily limited to just research. They integrate current best-available research and evaluation but also practice knowledge and skills, as well as patient values and experiences.

The clinically-specific conditions that I mentioned, which are tied to the leading causes of preventable maternal mortality and severe maternal morbidity each have their own associated bundle. These include obstetric hemorrhage, severe hypertension in pregnancy, safe reduction of primary Cesarean birth, care of pregnant and postpartum people with substance use disorder, perinatal mental health conditions, postpartum discharge transition, cardiac conditions in obstetric care, and sepsis in obstetric care

Each bundle is divided into what are called "5R's." These groups bring together considerations and possible actions for addressing the conditions. The 5R's include readiness, recognition and prevention, response, reporting and systems learning, and respectful, equitable, and supportive care.

If you're looking at this graphic, you've probably noticed that on top of being one of the 5Rs, "respectful, equitable, and supportive care" is positioned at the center as well. This is because in addition to having its own "R," that pulls together the considerations and actions that for most respectful, equitable, and supportive care for a given bundle as a whole, these considerations and actions are also threaded into each of the previous "Rs" and their elements. It's meant to make sure these thoughts and actions and recommendations and considerations have spread throughout the whole process of each bundle.

I know this slide is a lot, so please don't feel compelled to try and read it all. I'm sure these slides are going to be shared. I wanted to give you kind of a better understanding of what the five "Rs" might look like in action. This is intended to serve as kind of a brief example using AIM's Obstetric Hemorrhage Bundle.

For this bundle, you'll see that "readiness," being ready, might mean a hospital birthing facility maintains a hemorrhage cart so that it's ready to go. “Recognition and prevention" could mean collecting and sharing data around blood loss with hospital staff to make sure this problem is elevated and on everyone's radar so that they are more well-positioned to respond, to have buy-in to perform the other activities or the other elements of the Obstetric Hemorrhage Bundle. A "response" element for obstetric hemorrhage might include developing an emergency management plan, while addressing "reporting and systems" could mean a focus on performing reviews of serious complications to identify like any systems issues. A "respectful, equitable, and supportive care" element might mean including each patient and their family in huddles and debriefs on the care plan after an obstetric hemorrhage event.

When talking about the impact of activities like the ones we just kind of went through for obstetric hemorrhage or when talking about the impact of the AIM Program as a whole, one thing that we have to do is acknowledge the fact that impacting maternal mortality and severe maternal morbidity rates really involves long-term sustained efforts at multiple levels and across multiple systems. Because of that, we know that many factors beyond AIM patient safety bundles, in addition to AIM patient safety bundles, can have an impact on maternal health and those adverse maternal health outcomes.

This means we can't in good faith make direct causal statements about AIM patient safety bundles and any reduction in maternal mortality and severe maternal morbidity. However, our participating AIM birthing facilities -- they, for one, do explore data on SMM events in their hospital as a way to understand and determine whether the things they are implementing -- whether those bundle steps and any outcomes that are associated with them are improving over time.

Additionally, each year AIM state and jurisdiction teams write impact statements similar to the ones that are on the slides. These are just kind of like snapshots of impact statements, but they write these impact statements to describe the birthing facilities in their states, the changes they've made, or the actions they've implemented, some of the results that they've seen related to AIM patient safety bundles. These impact statements cover improvements in things like timeliness of care, availability of equipment,

implementation of new policies and procedures, and coordination of resources and services that were outside of the hospital setting.

These impacts are achieved and noted because they happen through those continuous quality improvement cycles, what many of you may know as PDSA cycles, the Plan-Do-Study-Act cycles. They implement those PDSA cycles to determine what activities are effective, and what activities are effective. Then they make small changes each time they run a PDSA cycle, as needed, throughout implementation of one of these new elements or one of these new activities to determine their effectiveness and how they might have impact over time.

To quickly wrap up my portion of this webinar, I did want to make the connection between AIM and our federal partners, like CMS, to advance the work of including the general health outcomes. At HRSA and in our AIM Program, we work closely with our colleagues at many federal agencies, including CMS, to elevate the work of AIM and ensure the continuous quality improvements effort associated with the bundles are reaching our birthing facilities in the United States.

I mentioned earlier that HRSA is often referred to as a "grant-making organization." While this role and the legislative authority for AIM do give HRSA the role of developing and managing the AIM Program and the bundles, we really, truly rely on collaborations with our federal partners to elevate AIM, get the word out about the program, and address adverse maternal health outcomes like maternal mortality and severe maternal morbidity.

As an example, we work closely with our partners at CDC to manage funding to state perinatal quality collaboratives. As I mentioned, they are often the ones that are the state-based team for AIM bundle implementation. We work with them to ensure alignment of AIM work across the different funding streams. We work with them to build connections that create value-add for our states that might get PQC funding and AIM funding. We build strong connections to and influence with, and potentially even partner together to reach hospitals working on AIM bundle implementation or sustainability. For all our federal partners, we continue to share across agencies to move funding opportunities and resources that ultimately support AIM work to ensure all of our awardees stay up-to-date and in the know.

As AIM continues to grow among states and among birthing facilities, we rely on these collaborations to support the program and the teams implementing the bundles, both on a programmatic level and a policy and regulation level. As someone who is very steeped in AIM as a program and as a funding opportunity, I am personally so excited to continue building upon these relationships to ensure AIM is teaching hospitals and birthing facilities and patients who need it most both to include patient care and safety and to ultimately see changes in those preventable causes of maternal mortality and severe maternal morbidity in the United States.

With that, I want to thank everyone for the opportunity to present. Again, this is a program that our team feels very strongly about. It really means a lot to us, so I love any opportunity to share and talk about the program. You see here platforms that you can reach out to HRSA on. You are welcome to also follow up with me directly. I realize that I somehow did not include my email on these slides, so I will pop it into the Chat in just a moment to make sure that you guys have access to that. Should you have any follow-up questions or comments about AIM or any of our other funding opportunities, I'm happy to field questions. With that, I will now turn things back over to Lekisha on the Mathematica Team.

[Lekisha Daniel-Robinson] Thank you, Sarah, for your overview of the program and some ways to partner with it. And, yes, you noted the slides will be available to registrants and all others. The slides will be posted to Medicaid.gov within a couple of weeks, and we will send a note to registrants once the webinar information is available. We can also include your contact information there. We appreciate your presentation. Now for a state perspective on collaborating with partners, I wanted to turn to Emily Stauffer Rocha. the Director of Clinical Innovation of Medicaid and CHIP Services in Texas Medicaid.

[Emily Stauffer Rocha] Thank you, Lekisha. I'm going to go over very quickly some items to articulate about Texas so everyone has a quick lay of the land of what's going on here in Texas; and then I'll get to

the part that I think everyone's interested in hearing, which is how we have really fostered our interagency collaboration here in Texas.

Some quick numbers about Texas Medicaid. These are numbers as of April 2023. I'm sure you're all aware, the data is slightly delayed when it comes to Medicaid, but as of April 2023, we had about 5.9 million individuals enrolled in Texas Medicaid and CHIP across all of our programs. We know that approximately half of the state's children are Medicaid or CHIP beneficiaries. We now have over 95% of Medicaid beneficiaries that are enrolled in some sort of managed care plan, and we have 16 managed care organizations.

First, I want to talk a little bit about House Bill 12. As many of the states are extending postpartum coverage to 12 months, in a quick 20 seconds, that's what House Bill 12 did for us here in Texas. Before March 1, 2024, postpartum coverage for women on Medicaid and for someone under the age of 18 who becomes pregnant who's on CHIP was provided two months after their pregnancy ended. Our effective date was March 1st of this year, and coverage has been extended to 12 months because of House Bill 12. The 12 months of postpartum coverage begins the month after the pregnancy ends. For example, if a baby is born in May 2024, the 12-month postpartum period begins in June 2024 and continues until May 2025.

Who is eligible to receive extended postpartum coverage? We've got some information here on the slide. The Medicaid or CHIP recipients who are pregnant or become pregnant will have coverage through the 12-month postpartum period. Medicaid or CHIP recipients who were enrolled while pregnant whose coverage ended however remain within the 12-month postpartum period will have their coverage automatically reinstated effective March 1, 2024, for the remainder of their 12-month postpartum period.

Women who received services while pregnant in Texas that would have been covered by Medicaid but who applied for Medicaid after their pregnancy ends will receive coverage for the rest of their 12-month postpartum period. They also may apply for coverage of unpaid medical bills for up to three months prior to their application month.

We did of course have a transition period, and we have a couple of notes with how this can be a little bit logistically challenging for the managed care organizations who were overseeing these beneficiaries. Full coverage Medicaid or CHIP was automatically reinstated effective March 1st for women who were enrolled in Texas Medicaid or CHIP while pregnant. They had to of course still be within their 12-month postpartum period as well as still living in Texas.

What are the services that are covered? The full Medicaid or CHIP member services. They remain available for the 12-month postpartum period, and they are things such as medical checkups, prescription drugs and vaccines, hospital care and services, X-rays and lab tests, vision and hearing care, access to any kind medical specialists and mental health care, and treatment of special health needs and preexisting conditions. We do have a mailbox available and a couple of resources, so if anyone wants to learn more, you can click through those once the slides are distributed.

The next program I want to highlight is Healthy Texas Women. Healthy Texas Women is dedicated to offering family planning and preventive services at no cost to eligible Texas women. Our goal is to increase access to preventive care including screening and treatment for conditions such as hypertension, diabetes, and high cholesterol in order to have a positive impact on maternal health and reduce maternal mortality. This also helps to increase access to women's breast and cervical cancer services and promote early cancer detection.

Who is eligible for HTW? Eligible women can receive HTW benefits if they are between the ages of 15 and 44. Anyone between the ages of 15 and 17 must have a parent or legal guardian apply, renew, and report changes. They must be a U.S. citizen or qualified immigrant. They must be a resident of Texas. Obviously, they currently do not have health insurance. They are not pregnant. This is why I'm talking about this program as well, because if they are pregnant and eligible for Medicaid, then they would be on the other program so they cannot be pregnant with HTW. They must meet the income requirements of 204.2% of the federal poverty level.

We also have a program called HTW Plus. It is a limited postpartum care services package for women who are enrolled in HTW. Eligible women can receive HTW Plus benefits if they meet eligibility requirements for HTW and have been pregnant in the past year prior to HTW enrollment. This is a quick overview of the covered services for HTW, which is on the left side of the screen, and HTW Plus, which is on the right side of the screen.

This is focusing on the behavioral health services. Of course, all HTW services are covered for HTW clients. These are just going into a little bit more specifics of what services are offered in which programs. Here are some resources, again, if you'd like to learn more about our programs. Once the slides are distributed, then you can check out our links here.

I'm going to switch over to our sister agency, the Texas Department of State Health Services, which we sometimes refer to in short as DSHS. The Texas Department of State Health Services, or DSHS, is our state public health agency. This is a quick overview of all of the things that they work on, including their goals and some of their key programs. As you can see, on the right column we do have the Texas AIM Initiative, which is what I'll be going into more detail on next.

TexasAIM, which is what we call our AIM Program here in Texas, we were required to create our TexasAIM program thanks to Senate Bill 17, which was in the 85th Legislature and the 1st Special Session. For those of you who are not familiar with Texas legislative sessions, our State meets every other year for the first I think it's 170 days of the year, so approximately January through June. They meet in odd years, so we are getting ready to start our 89th Legislative Session in January. AIM was established in the 85th Legislature; and then we supported again in the 2023-2024 General Appropriations Act, HB1, for maternal mortality and morbidity. So we continued the work.

We launched our first bundle in 2018, and this was focusing on severe hemorrhage in pregnancy. It was a highly successful bundle and saw over 98% of birthing hospitals participate in this bundle. TexasAIM then moved into the severe hypertension pregnancy bundle in December 2022. There were 204 of the 223 hospitals with obstetric services participating in this bundle, which is going to conclude this month. The Opioid and Substance Use Disorder Bundle, or OSUD Bundle, kicked off in the in-person learning collaborative with a total of eight hospitals in August of 2023.

DSHS does have some future plans. We plan to implement future bundles, including Substance and Obstetrical Care in 2024 and Cardiac Conditions in Obstetrical care in 2026. We also plan to implement the Opioid and Substance Use Bundle statewide in 2025. This bundle is going to include an inpatient and outpatient component, as well as integrate key portions of the Mental Health Bundle into the implementation.

We did hear a little bit of the overview of AIM from our prior speaker. AIM stands for the Alliance for Innovation in Maternal Health funded by HRSA national cross-center commitment designed to lead the development and implementation of patient safety bundles. The patient safety bundles are structured in a way of improving the process of care as well as patient outcomes. When performed collectively and reliably, these bundles have been proved to improve patient outcomes.

Here in Texas, we offer two participation options. We have two levels of engagement, the Basic and the Plus. TexasAIM Basic participants report structure and process measures and have the opportunity to participate in quality improvement webinars, network with other hospitals, and receive technical assistance throughout the process.

TexasAIM Plus includes all the components of TexasAIM Basic, as well as joining a comprehensive learning collaborative that better assesses improvements and creates a network of support from partnering hospitals. The hospitals in TexasAIM Plus complete all of TexasAIM Basic data reporting requirements, as well as additional quality improvement measures; attending in-person learning sessions; and participate in learning collaborative meetings, coaching and training calls, and site visits. They also have access to peer-to-peer mentoring, targeted support, and access to additional resources and partnerships.

These are some of our TexasAIM enrollment numbers. I know we are getting a little short on time, so I'm just going to skip through a couple of slides. Here you can see the hypertension participation. We have more than 1,700 hospital improvement members working to make health care safer, so I always love these maps. It makes it easy to see where improvement is going on.

This is a quick historical timeline of our Severe Hypertension in Pregnancy Bundle. The initiative kickoff occurred in December of 2020 at the TexasAIM Summit and Leadership Meeting. It integrates and centers principles addressing health disparities into the bundle implementation and process improvement, as well as centering survivor voices. The Severe Hypertension in Pregnancy Learning Collaborative 2.2 was launched in January of 2023. There were in-person learning sessions in February through June, and we are having a Harvest Meeting this month. Then our upcoming TexasAIM Summit is this December.

I will wrap up with a little bit of how our state Medicaid agency -- the Texas Health and Human Services Commission -- is partnering with our Department of State Health Services in our interagency collaboration. We've worked together on multiple occasions; but one of our recent affinity groups, a learning collaborative that we participated in, was the Immunization Community of Practice, which lasted from 2021 to 2023. It was hosted by the CDC and Academy Health and focused on increasing immunization rates among low-income children and pregnant women.

We were one of eight states selected, and of course we partnered with the Department of State Health Services. Our three goals are there. Each of those goals had some action items listed underneath them. Since the project has now concluded, we have continued the good work because we really enjoyed working together. We now meet quarterly; and as needed, we'll hold smaller meetings to discuss some work on focus topics.

One such time that we worked together was the end of the public health emergency, and really there were things when it came to the end of the public health emergency that the Medicaid State Agency as well as the Department of State Health Services needed to do. It really was helpful that we had this existing line of communication and partnership of working together. We were able to facilitate open communications and align the work for both of the agencies, so everyone was on the same page on programs that were ending and funding that was ending and other things that were kicking back in from pre-pandemic policies. Everyone was aligned in their work. Leadership from both agencies benefited from the information; and we were able to, like I said, align our internal processes and plans for the future. We just reinforced that we really enjoyed this type of communication.

That led us to deciding if it's not broke, don't fix it. Let's just create another one, and we'll start working on maternal health. We now have our Maternal Hypertension Interagency Workgroup. We meet quarterly. Each agency has some items that they report out on and update policies/programs. We always review each agency's channel of communication as well as our sphere of influence. That way if there's a message that one agency needs to get out, we understand how each agency can work together to make sure that really hospitals and providers throughout the state are well up-to-date as to what is going on. We always discuss potential metrics to monitor for success.

What's next for Texas as we work on maternal hypertension? We're identifying some potential action items such as considering managed care contract language, notices to managed care organizations and hospitals. We're reviewing some quality metrics and seeing where we can align on those and start monitoring for improvement or doing improvement projects. We're identifying some opportunities for managed care organization engagement with the AIM bundle, and both agencies are supporting certification for Birthing Friendly in all of our Texas certifications for hospitals and providers.

A couple of my parting tips -- if you are looking to partner with your state Medicaid agency and your state Public Health agency, you want to know what ingredients make a collaboration successful and what makes both agencies really enjoy working together. These are four things to cover: Leadership support and participation is necessary. If you live and work in a state where you are all under one umbrella, you might not need a memo of understanding. Some states will require it in order to send things like data back and forth between agencies. Your open line of communication. And then diverse participation -- having people from clinical areas, operational areas, as well as data areas participating in your larger meetings.

These are a couple of my tips. If you want to steal our success, we like to say to steal shamelessly and share seamlessly. If they're going to work together, we suggest everyone decide on a specific topic, and that way you have a lot of focus in your meetings. Both planning and brainstorming together really helps to make sure that each agency is on the same page as well as you're able to create interventions in programs and policies that support what each agency is already doing.

We look at the scope of practice for each agency and then decide what each can contribute to achieving the goal. We create SMART goals, so dates for completion and tracking progress are very important. We maintain communication. Set up meeting invites for the year -- this one is for any of you who are overly organized. It's easier to put a meeting on someone's calendar and then be able to cancel it or change it if need be instead of trying to find time. I always suggest that you put up your meeting invites for the year. Have everybody report out -- both agencies, different stakeholders. Plan lots of time for discussion on your agenda. If you have the opportunity to participate in an affinity group or learning collaborative, getting input from other states is always valuable. That is my last slide. If you have any questions, my email is here. Thank you.

[Lekisha Daniel-Robinson] Thanks so much, Emily. Appreciate you providing the state perspective and addressing some questions that have already come in the Chat with your slide on stealing instead of recreating. That actually answers a couple of questions.

I'd now like to open it up for discussion. As noted before, the instructions for submitting your questions are on the screen. There's a Q&A panel at the bottom right of the platform. The first question, perhaps this is for Kristen at CMS, wanted to know whether the AIM safety bundles are associated with the CMS Birthing Friendly designation for birthing hospitals.

[Kristen Zycherman] They are one of the elements that you would allow a hospital to answer that question in the affirmative. It's not the only element that would fit the criteria, but it is one of the things that could fit the criteria for that -- so, yes.

[Lekisha Daniel-Robinson] Very good. Next question is about whether or not oral health is covered during the postpartum period. That question is for Emily in Texas.

[Emily Stauffer Rocha] I don't want to say the wrong thing, so I would probably point you to one of the resources that I listed on there to look through everything that was included. That way, you can see everything that's included in our postpartum coverage.

[Lekisha Daniel-Robinson] Okay, thank you. *"Are all of the AIM bundles open source?"* In other words, where can details about the bundles be found? That one is for you, Sarah.

[Sarah Wright] Yes, they are open-source. There is an AIM-dedicated webpage, saferbirth.org. I will also add it to the Chat in just a moment. But it has a wealth of resources. It has all of the bundles, all of the background information on them, the different elements, considerations, as well as multiple resources to support the bundles. There are learning modules for each bundle, which are kind of like quick half-hour bite-size overviews of each bundle.

There are ways to sign up with the communities of learning; and there are technical assistance presentations, or TAP webinars, on a huge number of topics that you can sign up or watch past versions of. There's several different types of toolkits. There are just all sorts of resources that support bundles as well. I'd highly encourage you to check out the saferbirth.org website when you get the chance.

[Lekisha Daniel-Robinson] Great, thank you so much. I'd like to move to our announcements and upcoming opportunities. In the fall, CMS will convene two affinity groups focused on this webinar series topics, which include maternal mental health and substance use and improving hypertension control.

There will be an Expression of Interest webinar on September 17th at 2:00 p.m., where we'll have the opportunity to talk more about what it means to participate in one of the affinity groups. Information will be

available via website and we're going to drop that in the Chat. The Expression of Interest Form is coming soon; but again, September 17th for that overview webinar that was rescheduled from before.

You may already be aware that the Transforming Maternal Health model opportunity is available. Applications are due on September 20th. The NOFO information is available via this link. The NOFO webinar overview session was held, and there's a recording for it as well. Participating in any of the MIHI affinity groups does not preclude state Medicaid and program participation in the TMah model, so we actively encourage you to participate in both if that is of interest to you.

Maternal health resources are available on Medicaid.gov. A couple that we note here include the Maternal Health Infographic, Maternal and Infant Health Quality Home Page. There is a Highlights for Improving Maternal Postpartum Affinity Group posting resource there as well, so a number of different resources available. Again, the slides will be posted; and we will send notifications to registrants of its availability.

With that, I'd like to close today's webinar. Thank you for participating. As you exit if you could complete the survey, it will be very informative for the future programs that CMS holds. Thank you, everyone, for joining.