[Derek Mitchell] I wanted to welcome everyone to today's webinar. My name is Derek Mitchell. I'm an event producer with Mathematica. Thank you for attending today's Medicaid and CHIP Maternal Health Webinar Series. This is the fourth webinar in the series titled Addressing Hypertension Before, During, and After Pregnancy. Before we begin, we 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 captioning. We welcome audience questions throughout today's webinar through the Q&A panel, located in the bottom right corner of your screen. If you would like to submit a question, please select All Panelists in the drop-down menu. And then click Send to submit your questions or comments. We'll be monitoring the Q&A throughout the webinar, and we'll address as many questions as possible.

If you have any technical issues, please use the 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 in your browser window. We're asking you to please respond and provide feedback to 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 recording are posted on Medicaid.gov. Here's an illustration on, again, how you can submit questions and comments throughout today's webinar. Now I'd like to turn it over to Lekisha Daniel-Robinson from Mathematica.

[Lekisha Daniel-Robinson] Thank you, Derek. Welcome, everyone, to the Medicaid and CHIP webinar series, addressing hypertension before, during, and after pregnancy. I'll be serving as your facilitator today. We have a robust panel and discussion about the impact of hypertension and cardiovascular conditions during pregnancy, before, during, and after pregnancy, and the opportunities to address them. We'll hear from representatives of the CMS Center for Medicaid and CHIP Services, the Centers for Disease Control and Prevention, the California Maternal Quality Care Collaborative, and the Oklahoma Health Care Authority. We will follow with an opportunity for your questions and discussions. I'd like to now turn things over to Kristen Zycherman, the Quality Improvement Technical Director from the Center for Medicaid and CHIP Services.

[Kristen Zycherman] Thank you, Lekisha. On behalf of CMS, I want to welcome everyone and thank you again for joining another great webinar in our summer webinar series. The objectives for today are to provide an overview of the CMS Maternal and Infant Health Initiative and opportunities to improve maternal health outcomes in Medicaid and CHIP. To describe maternal hypertension and its contribution to maternal morbidity and mortality. To share information about CDC's new hypertension and pregnancy change package. And California and Oklahoma will describe some state strategies to improve screening, treatment, and care coordination of hypertension and other cardiovascular conditions in Medicaid and CHIP delivery systems.

This is our standard historical slide of the Maternal and Infant Health Initiative. If you've joined our other webinars, you've heard this before. It was launched in 2014 and our newest offerings are this summer webinar series followed by two affinity groups in the fall addressing maternal mental health and substance use, as well as maternal hypertension and cardiovascular health, which this webinar focuses on. These are leading drivers of maternal morbidity and mortality, so we wanted to specially address them in this newest phase of our Maternal and Infant Health Initiative. I encourage you to go and check out the Maternal and Infant Health Initiative website on Medicaid.gov. We have a lot of great QI offerings and resources related to maternal and infant health on topics that we've covered previously in MIHI, and that's where our previous webinars live for this webinar series. Thank you again for joining, and I'm going to hand it back to Lekisha.

[Lekisha Daniel-Robinson] Thank you, Kristen. We've put information in the chat as well. We have some links at the end of the webinar, and the slides will be posted within a couple of weeks. As Kristen talked about, hypertension and other cardiovascular conditions are leading drivers of

maternal morbidity and mortality. Here we present information that 21% of female Medicaid beneficiaries, generally speaking in the reproductive ages, have been told at some point that they have high blood pressure. This data is also stratified by age grouping, and race and ethnicity. These rates are higher than the national rates during pregnancy that will be presented by the CDC in a moment, but importantly shows how high the prevalence is within Medicaid and CHIP among female beneficiaries overall. With that, I would like to introduce Dr. Wright, Director of CDC's Division for Heart Disease and Stroke Prevention, to discuss the problems and solutions of hypertension in pregnancy.

[Janet Wright] Thank you so much, Lekisha. I want to thank my colleagues at CMS and CMCS for this wonderful opportunity to bring you some additional information about the problem that we're facing as a nation and to offer some solutions. If there's one word I'd like you to attach to this presentation, that is that I'm bringing you a resource. I hope it will be useful to you in your work ahead.

I'll start by just stating the problem. This is a case for hypertension and an intense and sustained focus on hypertension in the country. What I'm going to cover applies to hypertension broadly in the population and quite specifically to women of reproductive age and those who experience a pregnancy. First of all, it's common. Broadly in the population, one in two US adults has high blood pressure and the control rates are less than 25%. Out of people with hypertension, only about a quarter of them have blood pressures that are what we would consider safe and under control. The impact of undetected and uncontrolled hypertension is immense. It harms all body organs and is also associated with complications in pregnancy. The specific and intensely painful aspect of hypertension in pregnancy, for me, is that the damage done, the harm done is lasting. It affects not only that person during pregnancy, but it marks her for the rest of her life to have an elevated risk of heart disease and stroke. That risk starts to present itself earlier in her life than it might otherwise, and it also marks the offspring of that pregnancy for an elevated lifetime risk of heart disease and stroke.

The next bullet, we are losing ground. In the population generally, we are seeing control rates lower than we have in the past decade. We're literally losing control of hypertension and the prevalence of hypertension is increasing. That is also true of hypertension in pregnancy. We know that hypertension is inequitable and the slide that Lekisha showed documents that as well. We know that Black women, native women, native Hawaiian and Pacific Islander women all have higher prevalence of hypertension and hypertension in pregnancy, and control rates are lower. Within hypertension in pregnancy, we see higher prevalence and lower control in those individuals. Both generally in the population and pregnant individuals who live in rural environments. People who live in the South and in the Midwest. Mothers who are age 35 and older. Mothers who are in the lowest median income bracket. So many types of inequities are present in hypertension in pregnancy.

The next bullet is about hypertension being costly. The first cost of course, is that it harms individuals and devastates families. It affects workplaces and whole communities because of these largely preventable events due to undetected and uncontrolled hypertension. The dollar amount is also costly in that the estimates are $131 to $198 billion annually from hypertension. That is an underestimate because it does not take into effect the lost productivity that comes from hypertension-induced events like stroke.

This sixth bullet is my second favorite bullet on the slide. That is that, thank goodness, what works to detect and control hypertension in pregnancy is known. We know what works. It's time for all of us to help make that what happens throughout the country, regardless of section of the country, zip code, race, ethnicity, and the other factors that I've mentioned. My favorite bullet on the slide is that this is an opportunity for us to have a generational impact. As I mentioned, by addressing hypertension prior to and during pregnancy, we not only impact the life and health of that person, but also of the offspring from that pregnancy.

I'll just walk through a couple of data slides. First of all, this one will knock your socks off. This reflects 32 million births in the United States between 2010 and 2021, showing this dramatic rise in hypertensive disorders of pregnancy. That includes chronic hypertension. It's really a stunning increase. If you look at the relative increase over that period of time, it's about 113% increase. The next slide captures the high-risk factors for preeclampsia, one at a time. Preeclampsia is one form of hypertension in pregnancy. Here is a gentle rise, but a definite rise in pregestational diabetes, which is a high-risk factor for preeclampsia over this same period of time. On the next slide, we see a reduction in multifetal gestation. That too is a high-risk factor for preeclampsia, but we've seen a decline there. The next slide shows a primary driver for why we are seeing increasing rates of hypertension in pregnancy. This represents 125% increase more than doubling of chronic hypertension. What I want to emphasize here is that this is likely an underestimate because of the way we measure hypertension in individuals. I just want to bring to you a slide showing the complications. Both for the fetus and for the mother, in the short-term and the long-term.

The solutions I'm bringing to you today are contained in this Hypertension in Pregnancy Change Package. The strategies listed over on the right are those for which there's a strong evidence base for each of these. We have collected over 350 tools and resources from around the country, tried and true strategies that support the improvement of quality delivered in outpatient settings for people who have been pregnant or in a postpartum period.

We have on the left the interventions I mentioned, and on the right examples of strategies that can be implemented according to the characteristics of the population served, and the priorities within clinical settings. This shows change concepts, change ideas, and examples of the tools that are ready and customizable based on the priorities of the practice or health system in question. We have learned that antihypertensive medicines that are safe during pregnancy are not uniformly prescribed. This is an excerpt from the change package that allows clinicians to look and see which medicines are safe and get those in the formulary, clearly a QI intervention, no ACEs and ARBs. There is also a list of medicines that are safe during lactation. We know that there is clear, strong, evidence for aspirin used to prevent preeclampsia. This slide is an excerpt that shows the high-risk features and the moderate-risk features. The next slide shows the amount of money that can be saved if aspirin were prescribed according to those guidelines, over $350 million in projected cost savings.

In the change package, there's this diagram which shows the proper technique which allows us to prevent over-treatment and under-treatment, and the most accurate diagnosis for hypertension in pregnancy. These are resources showing coverage for SMBP for monitors, that is validated monitors, accessible and by state. We keep this up to date working with our colleagues at AMA. Patient information about the warning signs of preeclampsia is included in the change package. We have a list of things here where Medicaid and CHIP programs can get started. These are all extracted from the change package and I am happy to discuss those further with you.

The next slide shows our action forum which will convene with the inaugural meeting on August 6th. The link to join and register will be in the chat. This is a place for implementers and potential implementers to come together, exchanging best practices, identifying solutions, and sharing resources to accelerate the detection and control of hypertension in pregnancy. I would ask for you to do the best you can to disseminate this change package, to join our action forum. To help facilitate the implementation of these proven interventions in the people and the partners that you reach and help us improve the change package over time. There are resources here, and you'll get access to this slide deck. I have a final slide with some contact information. Please reach out to me or to Hillary Wall who helped pull this change package together. We look forward to working with you. Thanks very much.

[Lekisha Daniel-Robinson] Thank you, Dr. Wright. We'll now turn to Dr. Amanda Williams, an OB/GYN and Clinical Innovation Advisor with the California Maternal Quality Care Collaborative and

Stanford University School of Medicine, who will provide additional perspective on disparities and drill deeper on actions and a toolkit.

[Amanda Williams] Thanks so much. I appreciate the opportunity to represent both the CMQCC, the California Maternal Quality Care Collaborative at Stanford and our National Mission Advancement Council at the March of Dimes. What I'm going to do is introduce you guys a little bit to CMQCC and then some of our tools that we've developed for hypertension. Both detection, treatment and then our newer work in our low-dose aspirin initiative around preeclampsia and preterm birth prevention.

For those not familiar with CMQCC, we are our state's perinatal collaborative. Our mission is to end preventable morbidity, mortality, and racial disparities in maternity care in California. We've been around for 18 years and work hand in hand with the California Department of Public Health to take what we learn in our maternal mortality reviews- I'm privileged to be part of the Maternal Mortality Review Committee for the state of California- and not just grieve the deaths of the people who have lost their lives in this pregnancy and postpartum period, but take those losses and move them into action and really think about, how can we do better? How can we learn and help our member hospitals and every hospital that has maternity services in the state of California? We are a huge state. One out of every eight babies in America are born in California. We believe if we can move California, we can move the nation. We do have the lowest maternal death rate in the United States in California. We like to think that a part of that is the collaborative work that we do in addition to good policy and care provision. We're also the effector arm of the March of Dimes Prematurity Research Center. So again, taking research, taking these maternal deaths, and putting them into action.

Our secret sauce is the Maternal Data Center. We take our member hospitals, all 2,011 hospitals, and we get ICD-9 and 10 codes, procedures, etc., from those hospitals, monthly uploads. We have quality nurses doing some manual reviews both at the hospital level and at the CMQCC level. And then marry that with our vital statistics, birth certificates, death certificates, state newborn screening, and put that together in the Maternal Data Center linking the parent and the child. Then creating an interactive analytics tool for our hospitals to use, so that they can then do QI interventions with topics, then run collaboratives, whether it's sepsis, hypertension, community birth, supporting vaginal birth, preventing primary C-sections, etc. These collaboratives bring hospitals together of all different sizes and geographies to learn from each other, share best practices. Really engage our hospitals so that we can then move forward, develop our toolkits, and then make them available more broadly.

We know that the reason this is all necessary is because of the maternal mortality crisis that we have in our country. We know that this burden is not equally shared. Not only is hypertension not equally shared across different races, ethnicities, insurance types, we know that maternal death isn't either. For black and indigenous birthing people in this country, even when you adjust - and that research did come out of Stanford a year and a half to two years ago - for education, for college educated Black women, or for income, our highest income quartile in the state of California, our Black birthing patients are still twice as likely to die, and their newborns are twice as likely to die. If it isn't education, if it isn't money and those things being, sort of slang, if you will, for access or big drivers of access, then what is it? The “what” are many different things, but we cannot forget the impact of bias and systemic racism. That is incorporated into all of this quality improvement work that we're doing in California.

While we do have the lowest maternal mortality rate in the country, while our disparities in California are improving and we're super proud of them improving, they are still just as bad as the rest of the country. This is where my work comes in and I am proud to lead it. This takes a closer look. This is California maternal deaths between 2012 and 2020, looking at causes of death. For those who don't recognize the acronyms, the main drivers of maternal death in California are like most of the country, cardiovascular disease, hemorrhage, infection, hypertensive disorders of pregnancy, venous thromboembolism of different types and amniotic fluid emboli. What we're talking about today, these

hypertensive disorders of pregnancy, that's the light pink. As you can see, Black patients are disproportionately impacted by hypertensive disorders of pregnancy. I want to just double click on that little writing under where it says Black, which is scale. And the scale is one to three. So let that sink in, that Black patients die during pregnancy and postpartum so much more than their peers from other races and ethnicities that they don't even fit on the slide. You'd have to line up three slides and they'd still be the longest bar. When those patients look like me and my sister, that makes an impact. This is, again, a big piece of what inspires my work.

Fortunately, in California, because we have our toolkits, because we're so engaged in this work, we have seen improvement. This is our California maternal mortality looking from different causes. Again, the pink is the hypertensive disorders of pregnancy. You can see the last two time periods with these green arrows, there has been a 75% reduction in maternal death from hypertension. That is awesome. And we're super proud of this work and we want to share it with you.

So, what is in our hypertension toolkit? What is it that we're doing? If you go to our website, which is just cmqcc.org, you'll see on the left-hand side there are different initiatives and collaboratives that we have going on. This is what it looks like to go into the hypertensive disorders of pregnancy section, and this is open to the public. There are parts of the sites that are just for California hospitals, but this is open widely and we do want this work to get out across the country. So specifically, what's in there? There are slide decks. There are webinars. There are algorithms. It was neat to see our algorithm in Dr. Wright's slide that's in that broader package, bringing tools together from around the country. This is our suspected preeclampsia algorithm. This is a multifactorial issue, and all of you who do QI know that multifactorial problems require multifactorial solutions, because we don't know what's going to make a difference for that patient and her baby. We've got debrief tools so that we can learn for when things go wrong. We have order sets for your EMR. We have scripts. We have posters. All sorts of things in this toolkit.

For example, on the left, that's a copy of a poster that can be downloaded, laminated, put into the emergency room to help us identify pregnant patients, because we know that oftentimes in postpartum, people aren't even being asked, were you recently pregnant? We want our ED colleagues to really be engaged and be thinking about specific risk factors. There's lots of great tools inside the HEAR HER Campaign from the CDC to help educate families, in addition to providers and patients about what to be looking for if a patient has recently been pregnant. We also know that the vast majority -- indeed in California, 92% of the maternal deaths associated with hypertension disorders are after birth.

So let me keep moving forward. We know that we don't just have scripts. We have discharge follow-ups so that we can figure out how to leverage technology in order to get blood pressure checks done, to make sure that patients are getting appointments, tracking symptoms. These are all part of our toolkit. Now our new avenue is in prevention. Dr. Wright talked a bit about low-dose aspirin to help prevent preeclampsia and preterm birth, so I'm not going to go into details about it. But especially for our community members, public health colleagues, getting the word out that so many patients are candidates for low-dose aspirin to start around 12-ish weeks, continue through pregnancy. There are huge benefits, not just for the mom, but also for the baby in order to prevent preeclampsia, prevent preterm birth.

Yet we know these recommendations have been very slow to become adopted. Even patients with chronic hypertension who are the highest utilizing group, only 50% of them are taking them. Among black patients, it's only 10%. So, we have work to do. Instead of just saying, oh, they're not listening, we have to be more humble. We have to ask, what's getting in the way? Is it about the pharmacist? Are we having a hard time getting prescriptions? Is it with difficulty with pill taking? Is it fears about medication? Is it the mixed messaging that's going on? Is it stigma about the risk categories like race, SES (social economic status), obesity? We have to think about those barriers.

These are some of the steps in our collaborative that we've been taking. I'm just going to click through a few slides here so that you can see some of the work we're doing. For example, this is some of the educational material that's going up in the clinics. You can see the self-assessment tool that takes the more complex list of risk factors that Dr. Wright showed and makes it in a patient-friendly fashion so that patients and their families can assess. We're doing site visits to work with the clinics. We're doing educational webinars, and these are not just for California. These are open to everyone. Teaching providers how to discuss risk respectfully. Working with community members. We have a doula webinar. We have a webinar for pharmacists, really trying to engage all the people who are part of this process. Then really engaging our patient advisory committee. These are all paid experts in this live experience and making sure that their voices are there and that we listen to them.

Finally, we have the data support. Helping our clinics and hospitals build the data tools that are required. Then we integrate that into our Maternal Data Center and the QI interface that they might use for hemorrhage. They might use it to track their C-section rates. They can use it to track low-dose aspirin usage and then stratify. Everything in here can be stratified by Medicaid versus commercial pay, by race, ethnicity, etc. I think that is it for me. This is me and my preeclampsia, NICU baby, many years ago. Now he's off at University of Michigan, so this work is both personal and professional for me and I'm proud to do it with March of Dimes and with CMQCC. Thank you.

[Lekisha Daniel-Robinson] Thanks for sharing information about your own lived experience in addition to the work that you're doing in California. I'd like to now turn to Carrie Edwards, an RN and Chronic Care Management Supervisor with the Oklahoma Health Care Authority, along with Amy Allen, RN, a Population Care Management Supervisor, who will talk about working with Oklahoma Medicaid members with cardiomyopathy.

[Amy Allen] Thank you so much. Good afternoon from Oklahoma. My name is Amy Allen. I am here with my colleague, Carrie Edwards. We're both supervisors here at the Oklahoma Health Care Authority. I'm over the obstetrical program and Carrie is over the chronic care unit. We are excited to be here today and to share with you our journey on how we began case managing the perinatal cardiomyopathy in our departments. It all started, just to give you a little background, in June of 2021. Oklahoma became a part of the CMS Improving Postpartum Care Affinity Group Project. Working with our agency partners, the Oklahoma Perinatal Quality Improvement Collaborative, Oklahoma State Department of Health, the Oklahoma Mothers and Newborns Affected by Opioids, and other Oklahoma collaboratives that did a lot of the foundational work that helped us focus on the area to work on for our project. We also utilize the Member Advisory Task Force, where we take member feedback for center care concerns.

There are four different PDSA cycles that we started for Oklahoma within this project. In my area, I started 1 PDSA, looking at the proposed goal at how to reduce the rate of maternal mortality in African American and American Indian women with chronic conditions, to determine if we case managed these women or birthing people through the 12th week postpartum, will it increase the postpartum visit rate? Secondly, if they need a referral for chronic condition management, will that be made? Our efforts to begin with were to case manage five women with one nurse in our Population Care Management Department during pregnancy and through the 12th week postpartum. This nurse was to use motivational interviewing, open-ended questions, appointment reminders, surveys like the EPDS and other things like helping members obtain meals, lodging, and transportation. We discussed important topics with mom on pregnancy stages, fetal growth and development, labor, delivery, safe sleep, breastfeeding, family planning, tobacco cessation, drug use, and comorbid conditions, as well as follow-up care with the OB for the postpartum visit. We made calls monthly to members and continued this to the end of their pregnancy and into the 12th week postpartum. After the 12th week, we completed a warm handoff to our Chronic Care Unit and let them assist them with their chronic condition after pregnancy. We completed two full PDSA cycles, as you can see.

In our PDSA 1, we took five women with chronic hypertension and diabetes mellitus that were African American and American Indian. What we found, as you can see in number one, all women delivered. In number two, 40% attended their postpartum visit. In number three, 20%, or one out of the five, discussed their chronic condition with their provider. In number four, 60% had drug use in pregnancy. In number five, 40% had to have a CPS referral or a Child Protective Service referral completed at some point during case management. In our PDSA Cycle 2, as we moved these same five women to case management with our Chronic Care Unit, we found that all of our women were sent to Chronic Care Unit in number one. Twenty percent were currently active with case management when our PDSA cycle ended. Number three, none of the women accepted any additional resources from the Chronic Care Unit. Number four, 40% of the women had seen their PC care specialist, and we found that via claims and calls. Number five, 20% discussed their chronic condition with their provider. Number six, only 60% were unable to be contacted by the Chronic Care Unit in general.

So now what? We felt at this point that we needed to pivot. We did not see that our PDSA was fruitful for the work that was being done. We investigated, looking at some of the research. In the Oklahoma Maternal Health and Morbidity and Mortality Annual Report of 2022, we noted that 60% of the deaths over the most recent five-year period were determined to be preventable. We also noted that for African American and American Indians, one of the highest causes of death is hemorrhage and cardiomyopathy. With that in mind, our analysts pulled the data for SoonerCare and noted that there were over 30,000 births with Oklahoma SoonerCare. Which is 1.5% of women that had developed cardiomyopathy before, during, or after delivery. That was 450 women that could have potentially been reached by our departments. We felt this was also in the vein of the Chronic Care Unit, and that they would be a needed part of this collaboration.

What we did with that is PCM created cases on the current pregnant members that met the criteria for cardiomyopathy. We sent introduction letters. We mailed materials of healthy pregnancy, unable to contact letters if members were unable to be reached by phone, and closure letters when they were sent to the Chronic Care Unit or if PCM closed the case. We made monthly calls using the same motivational interviewing, open-ended questions. Giving education or appointment reminders. Completing the healthy pregnancy survey to find other barriers, as well as the PHQ-9 to monitor for depression. We used care plans to allow for continuity of care, giving members the same education we give all of our other obstetrical members, with the focus on their cardiomyopathy concerns as well as other comorbid conditions. We then gave warm handoff to our Chronic Care Unit for continued case management.

During PCM’s case management efforts in about an eight-month period, we have case managed over 59 cases. What we discovered was the difficulty once again in reaching our members or engaging the members on the phone. We found that many SoonerCare members change their phone numbers frequently, or they run out of minutes, thus making phone calls difficult. Oklahoma expanded postpartum coverage to one year, which gave our members more time to be reached by the Chronic Care Unit after delivery, which was a huge win, as we normally had only two months coverage, and now it is one year. Prior to expansion, we were able to identify pregnant women with eligibility a category of a P1. We then got expansion of the HAP, and this changed or masked our ability to view members who had eligibility due to pregnancy.

Lastly, Oklahoma began Managed Care, which took the non-disabled, non-tribal citizens, as well as any tribal members who would choose to opt in into managed care. Thus, our population that we case manage now are the disabled and the native populations if they choose to opt out of managed care. One area that we found that seemed to have a potential connection to cardiomyopathy is a diagnosis of anemia when our nurses view claims. We are not sure if this is significant, but it's something that we have noticed as a possible connection. Moving forward, since one of the populations that we have been case managing is Native American or American Indian that we have been focusing on with cardiomyopathy, our unit decided to start case managing all of our American

Indian pregnancy population with the healthy OB outreach program. In Oklahoma, we have 39 recognized tribes, and from our American Indian Fast Facts, we found that of all Medicaid members, including traditional SoonerCare, SoonerSelect, Managed Care, and Insure Oklahoma, that 17% of the enrollments are that of a native population.

For Oklahoma SoonerCare alone, non-tribal is there in blue at 67%. Associated with the tribe is in orange at 31%. Then we have 2% in gray, those of a tribal population that are tribal affiliated but they do not affiliate with a name. That is around 33% of our population with SoonerCare that is considered tribal. Lastly, in our high-risk OB programs where most of our cardiomyopathy members would typically fall, we found that 17% are native and 38% are those that we case manage currently have cardiomyopathy and native and American Indian citizens already. Other areas that we focused on is substance use disorder, which we have collaborated with our OU Perinatal Hospital partner to be a part of their STAR or Substance Use Treatment and Recovery Program to help keep moms and babies together while getting treatment, as well as focusing on mental health for these members. As we complete our care and care management and after the postpartum call with our cardiomyopathy members, we give a warm handoff to our chronic care department with Carrie Edwards. I'm going to hand this over to Carrie to let her discuss the care given from the chronic care department at the state of Oklahoma and to give overall data of the program.

[Carrie Edwards] Thank you, Amy. Hello all, my name is Carrie and I'm the supervisor for our chronic care management team. Like Amy talked about, members with cardiomyopathy are managed by her team while they are pregnant, and they quickly identified this need to continue efforts beyond pregnancy. Referrals were made to my team of nurses so that we may build on the foundation that they started and extend their care management efforts well beyond delivery. Our chronic care team is a group of five nurses and myself who offer ongoing case management for members who have chronic conditions like cardiomyopathy that can be impacted by lifestyle behavior changes. My team receives cases for cardiomyopathy in two ways. The first way is a referral from Amy and her team after delivery and completion of the high-risk OB program. Secondly, is through data mining done by our data and quality teams for members who have delivered in the past year, who also have a diagnosis code of 0903. This is sent to us in a report.

We were able to identify 104 members who met this criteria, and all 104 women were offered care management services. Amy's team was able to offer case management for 59 of the women with cardiomyopathy while they were still pregnant. Then through direct referrals and through data mining, 85 women were offered care management after they had delivered. This was provided in a few ways by our internal chronic care team, and by making referrals to one of our externally contracted care management partners through the health access networks. They were able to provide face-to-face case management at the PCP’s office, as well as telephonic case management like our teams. Additionally, we experienced a care delivery model change in the past year by implementing managed care. Some of the women were referred to our managed care entities for continued efforts. Let's dive a little deeper into the outcomes.

Of the 45 cases opened to my team, 20 women agreed to participate in the chronic care management program. We call those members engaged. They are engaged with the nurse. They're answering the phone and they are having those crucial conversations around their health. We've looked at the outcomes of all the women identified with cardiomyopathy and compared those who did and did not actively participate in our program. The blue represents the women who were identified and for some reason, they were unable to contact, or chose not to engage in care management. The gold represents those who did actively participate with a chronic care nurse. I was really pleased to see the number of women who received care from a cardiologist. Both cohorts were in the 90th percentile. Of those engaged with a nurse, 19 out of the 20 women were established with a cardiologist. One actually declined that referral. She felt as though her cardiomyopathy had resolved and chose to manage her health needs with the PCP. All 20 of the women were aligned with the PCP, and we know this is huge for health outcomes. One member or

5% had an inpatient hospital stay related to cardiomyopathy. Of those engaged with a nurse, there were zero ER visits related to cardiomyopathy. Overall, the best statistic is there were no deaths among the entire group.

Pictured here is Susan. She is one of the nurses on my team. This is a case she brought to our team huddle a few weeks ago. Karen delivered a healthy baby girl in December. By January, she developed cardiomyopathy and experienced a cardiac event that landed her inpatient for heart failure, peripartum cardiomyopathy, anemia, chest pain, and respiratory distress. Our data mining picked up on diagnosis code 0903 and her case was identified for care management. Susan, our chronic care nurse, engaged the member using motivational interviewing and found that upon discharge, Karen was prescribed Entresto, furosemide, and metoprolol. At the time of their conversation, Karen had run out of Entresto and was doubling up on her furosemide. At that time, she had not followed up with her PCP and was not established with a cardiologist. Susan did the social determinants of health assessment and identified that a barrier to care was reliable transportation and gas money. Susan assisted with scheduling a PCP appointment and arranged transportation and gas reimbursement through our SoonerRide program and coordinated with the PCP for a referral to a cardiologist. All while teaching the member how to navigate the healthcare system.

Some of the key elements to care management success have been monthly calls with the nurse and more frequent calls upfront. This is really to establish a relationship with the member, and to knock out some of those immediate referral needs. Ensuring the member is aligned with a PCP and a cardiologist, and the member is making time for those appointments. Then addressing social determinants of health and behavior health needs. Then diving deeper into medication education, and adherence and supporting lifestyle changes using motivational interviewing. All with the goal of member self-management. Not only cardiomyopathy, but all the identified chronic conditions. I cannot imagine the health outcomes for Karen if Susan didn't have those crucial conversations through care management efforts. This story and so many like her are exactly why we do what we do every day. The next slide has our contact information. Thank you so much for having us and please share your questions or suggestions. We are so curious to know what has worked well for other states.

[Lekisha Daniel-Robinson] Thank you, Amy and Carrie. We'll now turn to questions and discussion. We have an active Q&A portal at the moment, so I think we have time for just a couple of questions. Let's start with one about engaging with Medicaid beneficiaries. How are you working with OB/GYNs and/or primary care to communicate the purpose, rather, of the chronic care management unit? What are you doing if there is apprehension or other reluctance to participate in the program? That would be for the Oklahoma team.

[Carrie Edwards] Sure, absolutely. This is Carrie, and participation with one of our chronic care nurses, it's completely voluntary. The real goal is to reach out and connect with that person quickly. Part of that is through motivational interviewing. If I could drop one nugget for people to take away that engages patients and members quickly without this nurse-patient hierarchy, it would be motivational interviewing. Understand how to use that and connect very quickly. Then they can choose if they want to participate or not.

[Lekisha Daniel-Robinson] Great, thank you for sharing that. Another question is about how Oklahoma is coordinating outreach with Indian Health Services.

[Carrie Edwards] I might jump in on that one, Amy, unless you want to?

[Amy Allen] No, you go right ahead, Carrie.

[Carrie Edwards] We have an entire department dedicated to our tribal outreach. I have personally attended several of the tribal councils where all the different tribes come together, meet, and talk

about the challenges they are facing, the barriers that they have. We bring what they suggest back to our policy and our data people, and we try to work together. So, we have an entire team dedicated to bringing tribes into this mix.

[Lekisha Daniel-Robinson] Great, thank you. Let's move to a question for our CDC presenter and maybe CMQCC related to aspirin. Can we talk a little bit about if there is an allergy to aspirin? If you could say a little bit more about the known effect for preventing preeclampsia. If you can talk a little bit more about that solution.

[Janet Wright] This is Janet Wright. I think Dr. Williams is best positioned to talk about the allergy issue. I will say that what we've learned is that the use of electronic health record algorithms to identify individuals with these high risk and moderate risk factors lift up those individuals for clinical decision-making, have been shown to be very effective. These women are hiding in plain sight within care, but not being detected in a timely way. I think Dr. Williams referred to that. I'll turn the microphone over to her, though.

[Amanda Williams] Thanks for the question. In terms of aspirin allergy, we do not have a known alternative at this time. If a person would be at increased risk for developing preeclampsia, we would certainly recommend them getting a home blood pressure monitoring cuff. Or even better yet, remote blood pressure monitoring, to follow as soon as those blood pressures start increasing. In terms of how effective it is for low-dose aspirin for patients with one of the high-risk conditions or two of the moderate risk factors, decrease in preeclampsia by 15%. Decrease in preterm birth by 20%. Decrease in fetal growth restriction by almost 20%. Decrease in perinatal mortality by more than 20%. These are incredible impacts of such a simple intervention, so we've got to get the word out into communities. So yes, we need the doctors to make sure that they are screening appropriately. This is something that can be done with self-assessment and then brought to your provider. We're really hoping that our community and public health colleagues will be very active in this prevention effort as well.

[Lekisha Daniel-Robinson] Thank you so much. Let me go back to Oklahoma for a moment. In addition to educating Medicaid members on how to better navigate the health system and self-manage their chronic conditions, did you discover any changes that could make that navigation easier or simpler for Medicaid members? While you have the floor, if you can talk a little bit more about the data mining. If you are only using claims, is it certain codes? What else you might share about that?

[Carrie Edwards] Amy, you may be able to speak more to the data mining.

[Amy Allen] I am not 100% sure of all the different claim numbers our analysts use. But I know that there are multiple different codes that they do pull and they use claims eligibility. I'm not an analyst, so I don't know everything that they use. But I know that we have our analysts that pull it all together. Then they send me a list of members every month that I go through. What was the other questions that went on?

[Carrie Edwards] What was the first half of that question?

[Lekisha Daniel-Robinson] The first half was just about education of Medicaid members to navigate the system.

[Carrie Edwards] Absolutely. We do that in the chronic care team and Amy does that too on her team. It's through this relationship, this building with the member, on conversations, hey, I don't understand how to get to the specialist. Are you engaged with your primary care provider? Have you chosen one? Would you like to change? Do you trust that provider? It's walking through each of those steps as the issues arise. Then we can teach them hands-on to get to our website and learn

how to get to the member toolkit and understand all these little extra benefits that they have. So, it's hands-on and it's usually a partnership with the nurse.

[Amy Allen] I will also say that I've seen with my case management, that if a member has things in their life, like food, safety, housing, clothing needs, and those are not addressed, they're not going to be ready to make the health needed changes. You really have to make sure that they have the basic needs of life.

[Carrie Edwards] Yes, the social determinants of health.

[Amy Allen] Yes, it's very important. We really try to break those barriers down and reach those needs so that they can drop their shoulders and be ready to make those changes. Because if they're not able to feed their kids, they're not going to take care of themselves.

[Carrie Edwards] Yeah, I have $4 in my pocket. Do I really want to spend that gas money to get to the doctor? Or do I need to save that to add to next week's paycheck to pay my electric bill?

[Lekisha Daniel-Robinson] Thank you so much. I think those are really important items. We have a webinar coming up related to collaboration with AIM. Related to what you just talked about, we do have an announcement that we needed to make and wanted to make sure that you all were aware of. It's a new opportunity available through the Center for Medicaid and Medicaid Intervention, or CMMI, through the new Transforming Maternal Health Model, or TMaH. The TMaH model is closely aligned with MIHI initiatives that aim to improve maternal health outcomes. The centers have worked together to do some alignment, social determinants of health. The last question you were just addressing is certainly a component of this model that will be addressed and supported to address to improve maternal and infant health outcomes. I invite individuals to check that out if you have not already.

Additional resources are available at the website. As we close out today, if you could, we would invite you to answer the survey. If you have any additional questions, reach out to the Medicaid and CHIP QI mailbox. I wanted to thank all our panelists today. We had so many questions, we didn't have a chance to get to all of them. But the slides will be posted within a couple of weeks, which also contains the contact information for additional outreach to those presenters. Thank you, everyone, for joining us today.