CMS AFFINITY GROUP STATE SPOTLIGHT WEBINAR: POSTPARTUM CARE

Transcript

[Lekisha Daniel-Robinson] Hello, everyone, and welcome to the CMS Affinity Group State Spotlights Webinar: Improving Postpartum Care. I'm Lekisha Daniel-Robinson, a senior researcher with Mathematica and I will be serving as your host for this session. Before we move into the presentation, let's review the technical instructions to ensure that everyone has a good experience over the next hour. Please note that all participants are muted upon entry, but there will be an opportunity for Q&A. You may submit your questions using the Q&A panel. Closed caption and WebEx assistance can be accessed in the lower left of the window. Please contact our event producer, Derek Mitchell, through the Q&A panel if you have any technical issues.

At the end of the webinar, there will be a survey pop-up where we would ask that you provide your feedback, as the information will be used to improve future webinars. And, finally, we'll send an email to meeting registrants when the slides and recording become available and are posted on Medicaid.gov. For today's agenda, we will begin with opening remarks from CMS, hear about the Improving Postpartum Care Affinity Group, and then turn to our featured speakers from Georgia and South Carolina. We will leave a few minutes for Q&A and then provide updates on upcoming CMS quality improvement opportunities. I would now like to turn to Kristen Zycherman from CMS.

[Kristen Zycherman] Thank you, Lekisha. And, on behalf of CMS, welcome and thank you all for joining. Next slide, please.

This is some background on our CMCS QI TA program overall, which provides quality improvement technical assistance to states on a variety of topics for the purpose of improving care and outcomes for Medicaid and CHIP beneficiaries. One part of our TA program is to deliver TA through learning collaboratives, which involve a webinar series followed by an action-oriented affinity group, which helps states develop QI projects, analyze data, implement small tests of change and, ultimately, scale up and spread successful initiatives. Next slide, please.

CMS launched the Maternal and Infant Health Initiative, or MIHI, in 2014 based on recommendations from a panel of experts in the field. Initially, the MIHI focused on improving the rate and quality of postpartum visits and increasing the use of effective methods of contraception. Five years into the MIHI, CMS took stock of progress and reconvened an expert workgroup to provide updated recommendations for areas of focus. The new phase of MIHI was launched in December 2020 and since then, we have rolled out three learning collaboratives based on the workgroup recommendations. Next slide, please.

Today, the MIHI is focused on three areas as recommended by the workgroup: increase the use and quality of postpartum care visits, increase the use and quality of infant well-child visits, and improve maternal outcomes through decreasing the rate of cesarean birth and low-risk pregnancies, defined as nulliparous term singleton vertex, or NTSV, births. This figure shows the area of focus as well as how they are interconnected with the emphasis from the workgroup on the importance of both a dyadic approach, taking care of both birthing parent and infant, as well as a life course approach to improve outcomes. Next slide, please.

The concept of postpartum care has evolved over the years with the ACOG recommending all birthing people have contact with their provider within the first three weeks postpartum, followed by a comprehensive postpartum visit within the first 12 weeks. Comprehensive postpartum care goes beyond just recovery from childbirth, and includes physical, social, and psychological wellbeing, infant care and feeding, reproductive health, sleep and fatigue, chronic disease management, such as screening and treatment for diabetes and hypertension, and health maintenance. The importance of quality postpartum care is highlighted by the CDC data that shows 65 percent of maternal deaths occurring in the postpartum period and an estimated 80 percent of those deaths are preventable. In addition to the mortality statistics, we know that there are stark disparities not only in pregnancy-related deaths, but also in visit and follow-up rates. Next slide, please.

You can see from this slide that shows postpartum visit rates based on 2020 Core Set reporting that postpartum visit rates vary widely among states and range from 20.7 percent all the way up to 91.6 percent. So, there continues to be room for improvement. And we are happy to have representatives from all 50 states and D.C. and Puerto Rico register for this call to hear more about the lessons learned from some of our affinity group states. And I just want to take this opportunity to say that we have some more exciting resources coming soon related to improving quality and rates of postpartum care which will be available to all states. And you'll hear a little bit more about those later. So, now I'll hand it back to Lekisha. Thank you.

[Lekisha Daniel-Robinson] Thanks, Kristen. So, let's dive into the activity of the affinity group. The affinity group was an action-oriented experience supporting nine Medicaid and CHIP programs and their partners in the design and implementation of postpartum care quality improvement projects occurring between April 2021 and April of 2023. Next slide.

Each state focused on different opportunities and partners to improve postpartum care quality, equity and attendance among Medicaid and CHIP beneficiaries. I'll take a few moments to just highlight some of their efforts. Since we'll hear from Georgia shortly, I'll defer to their presentation, but will note that they focused on collaboration with each of their care management organizations to implement individual projects. In Kansas, the team focused on partnerships to address the needs of certain populations within specific counties. They partnered with March of Dimes for the design of a postpartum experience of care survey which was implemented by community partners including one of the health plans. There were also interventions that included community health workers and doulas to coordinate care and social determinants of health for managed care members. Kentucky had a multipronged strategy aimed at focusing attention on metrics via the development of a data dashboard, exploration of the use of doula care in partnership with their managed care entities, and the affinity group effort culminated with the state planning a statewide convening to deepen commitments and expand partnerships and cooperation to enhance service delivery.

In Missouri, the state team implemented a person-centered care coordination model to connect beneficiaries with care, resulting in significant improvements in no-show rates, and they're currently working on spreading that model beyond the fetal medicine clinic in which they piloted their efforts. In Montana, their efforts focused on improving communication between the community organizations, including managed care entities, and, so, they invigorated previously -- a previous workgroup around breastfeeding and postpartum topics. And, also, planned the development of a statewide maternal mental health taskforce. Oklahoma was focused on delivery system reform to managed care and laying a foundation for a strong quality improvement program. So, in the midst of all of those changes, they also sought to think about some near-term activities that could be passed on to managed care once that was up and running. So, they conducted an analysis of their data to understand risk among its members and

developed a case management program to support members with cardiomyopathy with -- starting prenatally and then transitioning to chronic care management postpartum. Next, please.

South Carolina, again, we'll hear from them a little bit later, focused on chronic conditions. In Texas, the state lead established a partnership with each MCO where the team lead served as a coach to those MCOs in their QI efforts focused on members with hypertension. So, some of the strategies included case management, the use of doula care, and dissemination of blood pressure cuffs to the membership. And then, finally, in Wyoming, the Medicaid agency sought to ensure referrals to a care management program -- its care management program for high-risk pregnancies. They conducted provider outreach and education and tested a web-based referral solution. They were, also, near the end of their participation, looking at establishing maternal medical homes with birthing hospitals. So, with that quick overview, I would like to turn now to the first of our featured speakers. Dr. Gloria Beecher is the Director of Population Health and Quality Planning within the Georgia Department of Community Health. Dr. Beecher?

[Gloria Beecher] Thank you, Lekisha, and good afternoon to everyone. We are very delighted to share with you today. But, first, I must thank Jane and the Mathematica CMS team, our CMO partners and the state team members who made this work possible. Next slide, please?

It was perfect timing for Georgia when the Postpartum Care Affinity Group was announced. We had already decided to put increased effort into turning maternal health outcomes northwards. Our state was close to expanding -- to extending postpartum care coverage to six months. Our quality strategy and performance improvement projects all focused on maternal care in some regard. And, so, we readily expressed interest to participate. And, once accepted, we reached out to our CMOs and select community partners to join as our meso and micro teams. Next slide, please?

Just a quick background. The state's MMRC latest data shows that almost 70 percent of all maternal deaths in the state occurred in the Medicaid population. All pregnancy-related deaths attributed to hemorrhage, mental health conditions, cardiomyopathy, cardiovascular and coronary conditions, as well as pre-eclampsia and eclampsia, were determined by the MMRC to be preventable. Further, our latest scores show that our postpartum visit rates have great opportunities for improvement when compared to the NCQA benchmark. Next slide. Thank you.

Given our improvement opportunities, our aim for the affinity group was to increase postpartum visit rates in select rural counties. We opted to target both provider and members in the testing. The tests were intentionally conducted at the granular frontline level. So, in form of ground-level performances, that may explain some of the whys in the postpartum outcomes that we are experiencing in the state. And, so, the tests, though very small, were done with intent to discover what goes on at the frontline. Next slide, please?

We started with three tests, and several tests were done, but we'll focus on three that were done in Year 1. Two of these tests were member focused. The other focused on the provider. The first test, we targeted seven postpartum members who we would give gift cards to if they kept postpartum visits. Two of the seven members met criteria for the gift card. Three were unable to be reached. And two made no appointment. The second test sought to provide billing education and postpartum practice care education to providers in an effort to increase postpartum care visits and quality of care visits. Sadly, after two sessions, the toll of the pandemic halted the testing. The OB educator was -- we lost the OB educator. And it was a challenge to find a replacement. We thought we'd include this test, however, because it speaks to the fact that the provider was readily receptive and welcomed the support of the OB educator. And, so, this is a practice that we could explore further to see the value and the benefits of providing

providers education, especially around Category II coding, as well as reminders for latest ACOG recommendations with regards to postpartum care.

The third test was conducted with members postdelivery, just to check on them once they were discharged, and to schedule for the postpartum visits if needed. And if they had their postpartum visit to get feedback as to the quality of care they received. Several women were contacted. Again, unfortunately, only one member was reached. Again, we included this test, although only one member was reached, because of what we learned from it. The member who was reached reported that she had gone to her postpartum care visit because her OB provider had talked with her about it and might have even helped to make the appointment for her. Some barriers we encountered include the loss of staffing. It was in the middle of a pandemic. There was noticeable difficulty in tracking and contacting members. There were no phones -- some had no phone cards; some had no identified secondary contact when we were unable to contact them. But what we learned is that both provider and member need customized support. It takes the engagement from -- it takes engagement from both provider and member to make performance improvements happen. We learned, too, that it might be a good idea to secure secondary contact information and talk with members about postpartum visits during pregnancy or prior to discharge from the hospital. Next slide, please.

So, we ended Year 1. In Year 2, there was a little hesitance to go forward because of several reasons: small tests, the slow pace of the progress we are making, abandoned tests. But we talked through it. We regrouped. And we had a moment when we pivoted and relaunched. This time, we allowed for more flexibility on the part of the CMOs, because they were central to conducting these tests. So, the CMOs selected their own aims, the population that we still work with and their testing sites. And, contrary to what we did for Year 1 where all the CMOs met at the same time with Mathematica, this time, we opted to use -- to doing one-on-one with Mathematica, as well as the state provided, in between, TA calls with each state on an individual basis. Next slide, please?

Thank you. We carried forward the provider-member approach because it seemed to have been very a very good idea. And, this time, we also did three different tests. The test -- the first test tried to sort -- to see if postpartum care rates would increase if providers were offered incentive and a list of the members who were due for a postpartum care visit. Two cycles were done. The first cycle saw a one percent increase in postpartum visit claims. And, so, that gave insight. So, we scaled up to 20 providers. Unfortunately, we did not get the participation as we would have liked. Less than half the providers participated but, nonetheless, they did. And we are still waiting on claims data to see if there's any change in the number of claims that were submitted for postpartum visits. Next slide, please.

Test two, similar to the first test except, this time, we had three different versions of a test that were run in three different regions to test -- to find out the most effective way to support providers to increase their postpartum visit claims rate. In Region 1, Category II coding education, as well as incentive information, were presented to providers in-person and via an email, that was a slide that was emailed to them. In the second region, incentive information only was presented, this time by a flyer. And, in the third region, in-person coding education was provided, but no incentive was offered.

As you will see on the next slide, next slide, please, on the tests where an incentive was used in addition to the coding information, whether it was by flyer or by in-person, we saw instances of eight to 10 percent increase in postpartum visit rates posttest. On the other hand, providing only the coding education, although there was a six percent increase, it proved to have been least effective. That was the lowest score. Next slide, please.

Test three, self-monitoring of blood pressure is a current and/or emerging practice, especially with persons with hypertension. And, so, test three was done to see if women were really -- if members were provided with a blood pressure monitor, would they really monitor their blood pressure? This just sought to establish the value of self-monitoring. It's one thing to make the monitors available, but would members really use them if they got them?

And, as you will see on the next slide, next slide, please, the first cycle was one member. One member was followed for four weeks and met the goal of weekly blood pressure self-check. This test was scaled to four members. And, as you can see from the chart on the right, one member measured every week for four weeks, one missed one week and two only checked once. It's noteworthy that the women who did well needed some kind of prompting or reminder to check their blood pressure, or they might have checked their blood pressure at the point of contact because they were contacted by the CMO partners who were conducting the tests to get the results of the blood pressure but noticed that sometimes, when they called, the member had not yet checked the blood pressure.

And, so, one thing that we learned from this, that we will see on the next slide, is that -- Some of the same barriers we had in Year 1: we were unable to reach members, we learned that providing a blood pressure monitor might not be enough for members to self-monitor, we need to check in with them. Contacting them leads to greater adherence to care. We learned that providing incentives to providers may boost postpartum visit rates. One big lesson we also learned was that claims-based data slows the PDSA test evaluation. Therefore, we suggest and we learned from that claims data is not the way to go. It's a great mismatch. In PDSA, you need your data readily to see if the tests are effective. And, so, that was something we took away from this. Some issues emerged during the testing that we would not want to ignore. For example, there were reports of the need to ensure behavioral screening and management of behavioral health conditions, addressing social determinants of health, for example, childcare doubled up as an issue for members not making or keeping postpartum care visits. Also, the need to promote postpartum care visits, especially among the young and experienced members, members who have had children before. Some expressed that they were doing well and had no need for postpartum care visits. The next slide.

Some promising outcomes were observed from these mini tests that can be adapted and/or are ready for spread. The state will continue to support the CMO partners to spread and adopt measures and incentives to support providers in their delivery of postpartum care, encouragement to check in with pregnant and postpartum members to assess needs and follow up as indicated, and to address some of the barriers and issues that were uncovered through the activities of this affinity experience. One very significant thing that came out of all of this endeavor is the state, currently, where we've conducted a value-based analysis, the state is currently considering coverage of blood pressure monitors for persons with hypertension and/or members with a history of hypertension or gestational hypertension during pregnancy. That's the end of our presentation from Georgia. And we thank you to have been an audience for us. Thank you.

[Lekisha Daniel-Robinson] Thank you, Dr. Beecher. And I am seeing some questions come in, but we will hold them until the end. But now we will turn to Dr. Witherspoon, who is with South Carolina Medicaid and also the co-chair of the Access and Coordination Subcommittee at the South Carolina Birth Outcomes Initiative.

[Patricia W. Witherspoon] Good afternoon to most parts of the United States, anyway. Before I proceed, I, like Georgia, would like to thank, again, Affinity Health -- I'm sorry, Affinity Group for helping us with this collaborative CMS/Mathematica. But, also, my statewide partners, the Bureau of Quality,

where community initiative sits at SC DHHS, was instrumental in this, specifically the manager of that program, Miss Tucker. And, of course, my co-chair, Dr. Tim Lyons. And, so, next slide.

When we speak of South Carolina's Birth Outcomes Initiative, that is South Carolina's peri-quality perinatal network. And, so, I wanted to like set you up to stage that we've had this entity for about 12 years. And because we've had this ability to pool so many stakeholders together for many years, when we went about interacting with the group, we were looking at a statewide change because we felt we had all the integral parts together, and we've been in this space for a while. So, as with Georgia, we found that about -- SC DHHS pays for over 60 percent of deliveries in the state of South Carolina, and approximately less than 70 percent of those women enrolled are receiving postpartum care. So, therefore, we knew this was an opportunity. And, not to belabor the point, we know that timely postpartum care can avoid unnecessary complications. And we have seen, as we looked at our data, that there are some geographic patterns in our state. And, lastly, we know that the low postpartum care is associated with high rates of severe mortality -- maternal mortality. Next slide.

I'm going to speak the aim. So, that's why -- when I wanted to let you know we've been doing this for a while, why our aim was so heavy as compared to maybe other states. And. so, we felt, by 2026, we could make some significant changes. We were going to increase our postpartum rate by 15 percent. We were going to align ourselves with the ACOG guidelines having more specifically about the fourth trimester. And there were definitely some chronic conditions that we wanted to pay attention to because when we look at our mortality -- Maternal Mortality Review Report later on, you'll see that these conditions have a higher propensity being associated with some bad outcomes. Our challenges, there were few on. One, geographic makeup of our state allowed us to see that our rural parts of the state were having some undue burden of challenges, hospital closures contributing to that. We noticed that we didn't have an uptake in our ESPR screening when we had such a really great rollout of the program. And then we, also, noted that we weren't communicating as well as we would want to across other programs in the state. So, when we look at strategies, we're hoping to improve communication, and we really want to do some replication and spread. Next slide.

So, our strategies. As I alluded earlier, the Bureau Quality, where our Community Initiative is housed, has taken upon looking at some pilot work that they're going to fund the second year of a CHW, which is going to emphasize perinatal care and diabetes. And, so, we believe that that engagement is going to have really great yield for us. And I will go a little later as I speak about our Diabetic Moms program. But primarily, we have noticed that they've done a really good job with this comprehensive wraparound care. And, so, they're now looking if they can replicate this model in resource poor states. Next slide.

So, the South Carolina Birth Outcomes Initiative will allow us to align our mesosystems. And we want to do a better job of aligning all of those stakeholders with our leadership arm of the South Carolina BOI, the Vision Team. We thought the opportunity now to reopen our mobile unit, we call it the SimCOACH. And what this gives is hands-on teaching tool that this mobile unit goes from hospital to hospital demonstrating the most recent changes in curriculums and aligning with the Alliance for Innovation on Maternal Health. That's the aim because we've been a participant since 2019. And we're using their different modules and bringing it to different sites, going to these different areas and showing them the newest innovation of care. And we, also, have a Maternal Morbidity and Mortality Review. And that committee report came out recently. And it let us also see that our leading cause of pregnancy-related deaths is cardiomyopathy. So, we're going to be working in our next iteration through the SimCOACH is working on the cardiac conditions in obstetric care. Next slide.

Other strategies are going to be the MOMs program, which is the management of maternal care. And, so, the Blue Cross Blue Shield Foundation operates these programs and they've been going throughout the state in a real deliberate manner, started in 2019. And what they're providing is this wraparound care, and, up to date, they've had 1,000 pregnant participants over three different centers. And, in each case, they're finding this wraparound comprehensive care has been proven to have some incredible results. Next slide.

Speaking of those results, they found that 75 percent of their postpartum MOM participants had attended at least one visit. And, as you see from 2020 up into 2022, they've steadily been increasing. They have noted some observations of disparity, in spite of these really wraparound cares, that between different types of patients with the type 1 diabetes or those with type 2, and they have just a difference in their attendance. And, once again, race and ethnicity also demonstrate some variability. And they'll delve deeper into as to why, but there is a disparity in attendance. Next slide.

This program, also, because it highlights on patients with diabetes, that 89 percent of their patients' A1c's are now well controlled. That is heroic. And the patients with gestational diabetes had higher rates of hitting their target as opposed to those who were actually pre-diagnosed with diabetes. So, gathering those women with gestational diabetes to show them the control is only going to be proven to be beneficial in their subsequent pregnancies. Some other things I just want to highlight is that they were able to work really hard with gestational weight gain, and they were able to provide provisional services and supplies, things we may not think of, like adding food, making sure if those individuals were identified as food insecure. Next slide.

The other one that we're quite proud of is BirthMatters. Now, BirthMatters is a community-based organization that is in our upper state. We call it Upstate. And this program focuses on providing free doula care because, as you know, doula care usually is out of pocket expense. But they're providing free doula care to young expectant mothers, and they'll follow them for up to 12 months of age of that infant. And what they found that they had made incredible inroads, but we have an opportunity to follow up on five moms who delivered in 2020 to give us some of their feedback. Next slide.

So, in all five, we found that they all reported that support was excellent. As you can imagine, having that human touch throughout the course of a very vulnerable time was valuable. But we did notice that when we talked about health promotions and behavior, as you can see, one out of five reported they checked the scar, or two out of five were checking blood pressures. Which was similar to Georgia when they expanded from one patient to four. Other items I'd like to highlight here is that two of the five moms were aware of Medicaid expansion, but three of them were not. So, we need to think about how are we informing our beneficiaries of the changes at our agency. Next slide.

So, when we think about spread, because that's what this is all about, going forward, we had I guess an unintended consequence. It turned out that two of those highlighted PDSAs went on to compete for national funding and they were very successful, which we are extremely proud of, the doula program. And then there was a program called Listening to Women, which is using a texting communication platform for moms. Next slide.

So, the PCORI grant recipient was improving postpartum care for Black pregnant and postpartum women. And what this Listening to Women project is going to do, they are going to compare their close interaction with these women compared to standard of care. And the measures they're looking at is to reduce emergency department visits, they want to see if we have any escalation in complications, and they want to follow them very closely at six weeks, three, six and nine and then, of course, 12 months postpartum. Next slide.

The additional program that received PCORI funding is Implementing the Doula Care that I talked a little bit about earlier in those five moms. They're going to spread this now specifically for Medicaid -- doula care and Medicaid to advance racial equities in severe maternity mortality. So, they are specifically going to target women of color and providing, once again, this free doula care, and follow them in the postpartum period looking specifically if they develop issues of chronic conditions, looking at mental health, substance use or abuse. And they're hoping to take this information so we can spread further. Next slide.

So, upon reflection, because I really wanted to take the remainder of my time to think about this here, when we thought about the BOI, as I stated, we had been doing -- living in this structure for about 12 years. And we've been very, very successful on previous statewide interventions, but we were able to bring stakeholders together, or I should say keep them at the table. And we had a very, very enthusiastic core of leaders through this entire time. But we needed to work through having all our -- communicating to all our stakeholders I think equally, and what we found is that we may not have done as well as we had wanted. But we were fortunate in the first year to have a very advanced data collection. But, as with everything, you know, just data was not available in the second year as readily available as it was in the first. So, the next slide.

So, change is slow. And I believe I've heard that also from Dr. Beecher that it is slow. And, sometimes, it can be hard that I think it's better to start small and to garner some wins before attempting such big changes. And I think life might have felt a little, you know, comfortable in the fact that we, like I said, have been in the quality space for a while, but this is such an important topic and requires so much coordination of so many individual players that have been identified, and actually new players in the field, like your CHWs and your doulas, that we probably could have done a little bit more if we started a little slower -- sorry, started a little smaller.

As I say here, having good intentions doesn't always end up in the results. But we have learned from this regardless. I believe knowing the goals and the missions of the leadership structure, because that can change, and if you're not, I think checking in often to see if we're really trying to go towards the same goals, then that can be problematic. And then, lastly, I think it is just really helpful being in this network to be able to talk to other individuals in this space. I think that has been really, really helpful in working with this multistate quality initiative, because we have more similarities than we have things that we don't have in common. And, so, to have someone work through something beforehand and show you the way is really helpful. So, I can't thank you all enough for allowing South Carolina to participate in this learning collaborative. Giving us this assistance has been invaluable. Thank you.

[Lekisha Daniel-Robinson] Thank you, Dr. Witherspoon. So, now we'll turn to questions and discussion. So, again, you may enter your questions in the chat window of your screen there. And I'll start off with a couple that have come in during the presentation. The first one was -- well, it came in during the Georgia presentation, but it actually could go to both of you. What advice would you give to another state who's starting to think about a quality improvement project in rural regions of their state, and particularly around postpartum care?

[Patricia W. Witherspoon] I'll go first. I think it's important for you to identify who are the parties and clearly, you know, back to the old basic aim statement, who are the individuals that are interested in helping, and who are you trying to help. And make sure that, as you bring these individuals around the table, that you can agree upon possibly one or two liked goals because that can derail you when you're working in one area, but you're trying to help others, and not knowing what their needs are as well. So, I

think starting really, really basic at that point of engagement, and then once you find all the people who want to be there at the party, start small and move forward. Dr. Beecher?

[Gloria Beecher] Absolutely, Dr. Witherspoon. I really have nothing to add to that. You've covered it all. Just maybe a word of caution that it's challenging to plan a project of any sort without -- for a group without actually knowing what their needs are. The place of assumption never happens in QI, or you'll miss your target, or you'll waste energy and resources. So, don't assume what's going on, actually visit or speak with folks who are at the frontlines to assess what the needs are. And in the conversation begin as to how to address those needs.

[Lekisha Daniel-Robinson] Thank you. And I guess you both have actually also talked about the value of starting small. Is there anything more that you wanted to share about, you know, running a PDSA cycle in this way?

[Gloria Beecher] So, based on the experience that we had with ours, one salient point that came up that I'd like to share is I think we probably needed to have spent more time prepping the partners, and reminding of what a PDSA cycle entails. It's not a large scale, it's not running a research project, you know, it's not doing p values to see if your interventions are effective. That kind of removes some of the frustration that might be experienced later on, because, indeed, these are very small tests. You can test with one person, one subject. You can test for an hour, five hours. You know? And, so, it's to really ensure that all the persons involved have a clear working definition of what a PDSA cycle is.

[Lekisha Daniel-Robinson] And to your point earlier, you mentioned, you know, having an understanding about the needs. How did you establish that? And what data did you use to do so?

[Gloria Beecher] Is that specific to me in here in Georgia?

[Lekisha Daniel-Robinson] Oh, sorry, yes. [inaudible] --

[Gloria Beecher] Okay.

[Lekisha Daniel-Robinson] For Georgia, yes.

[Gloria Beecher] So, we had a brainstorming session before we landed on a place. And we looked to our data from our latest performance, we looked through data from the MMRC, and we were mostly informed by those sets of data. Internally, we reached out to providers. There is one provider I am thinking of who runs an OB clinic in a rural county. And she shared some of the things she was experiencing, some of gaps in care because of barriers. And, so, those were primarily what informed us. I think she was very, very, very helpful in sharing with us her experience working in rural counties in the state.

[Lekisha Daniel-Robinson] Thank you. There are more questions about rural coverage. So, this one is about the use of home visiting nurses, if there are any available in your states for medical follow-up, especially in rural areas where there may be transportation barriers.

[Patricia W. Witherspoon] This is Dr. Witherspoon. As we looked in our current policy, there is documentation that a home visit is actually approved, one home visit. But what we're not sure of is if that is housed in our Department of Health and Human -- our Department of Health and Environment or is that because the hospital being paid. So, I know that that language is out there, and that is definitely one area that we are -- as we delve deeply in our policy and how we can strengthen it and find a way of paying for it. In just my readings of different papers, I'm seeing where they're doing that home visit maybe telephonically. And if that is able to be reimbursed in your state, that might be a way around.

Because what I have learned from this work is that if you are in contact with a mom, that ends up to have a higher yield than not having contact. Being face to face, telephonically, using an extender, but that contact is really the key is what we're starting to see.

[Lekisha Daniel-Robinson] Right. That's helpful. So, Dr. Witherspoon, another one for you around the diabetic program. Could you say more about what's entailed in the diabetic wraparound care?

[Patricia W. Witherspoon] I will try to do justice to it because it's an incredible program. So, these individuals are women that identified within one practice, and it is connected with an academic, and that's why we're trying to look at areas that don't have an academic institution around them. So, they have found that women that have been identified with gestational diabetes or have pre-diagnosis of diabetes, that they are going to provide them with the endocrinologist -- access to an endocrinologist, to a psychologist, a social worker, community health worker, an MFM, and they are going to see them at one location. And either during the interval of their pregnancy have that endocrinologist come in once a month face to face or have them communicate with the MFM that's caring for them. But the patient is central to this, and their care is all around -- it's like group care. But not that there are multiple pregnant women, but there are multiple providers wrapping around with their services.

What they did find is that it's a wonderful concept, but if the mother is not aware of the one-and-a-half-hour visit, they had gotten pushback. These women were not prepared to spend all of this time with this provider. But, as time has went on and they did a better job of prepping them in preparation, then now have found ways for them to get transportation, because some of them don't have reliable transportation, and a friend doesn't want to spend an hour and a half. So, they've then created vouchers or Ubers to get them where they needed to. As they did more social determinants of health screening, they found that they had food insecurity. So, now we have a program in our state called FoodShare, where we put together healthy vegetable boxes which will vary depending on the time of the year. But what they found, if you provide these wraparound services, you get the outcomes that I spoke of earlier. And, so, they have now gone from one part of the state to two other parts of the state, because we're divided in Lowcountry, Midlands and Upstate. And although they have different parties, they're still able to get close to the same replication. But that's in a resource-rich area. So, how do we find ways to determine what is the minimal amount of those individuals to be engaged with that woman and still get the great outcomes? And that's where they're working on in these subsequent years. But it's an incredible program.

[Lekisha Daniel-Robinson] It definitely sounds that way. There are quite a few questions related to the doula program also for you that have come in. And I'll try to combine them. So, one, are the doulas making home visits? How were the doulas funded in South Carolina? And then there's a question about telephonic visits, noting that in their experience it's hard to support, and there's some challenges with getting honest and appropriate readings from the postpartum patient or client.

[Patricia W. Witherspoon] Okay. So, the doula -- we do not have a policy to pay for doulas. But, in our state before this pilot, we had some hospital systems have taken upon themselves to have doula care provided to I think any woman that is interested in it. And how it's working is the hospital is seeing the benefit and, therefore, they're paying for the doula. This specific pilot is for -- is being through -- originally, it was two pilots. Like one of them was funded by, again, an outside entity, I think the TD Bank awarded this group some money for them to continue it on because of their early success that they've had. But by the doulas participating now in this PCORI -- and this PCORI grant that they're involved in has four out or five other states. And what they are is at different parts -- they're at different stages. And like Virginia, which I think legislatively has that already in place. And, so, they're just

trying to see what is going to work out best for them to finally roll out to these payers saying, "This is a worthwhile program for you to replicate for those who are -- to have some financial challenges, Medicaid specifically is going to be the program." Because we know private doulas are successful and they have great outcomes.

And, so, with the doulas, the programs that they're working on, we're trying to get a couple prenatal visits throughout the pregnancy, post -- and then, of course, after postpartum. And that makes this doula a little different -- this community doula program then your traditional paid for doula, which just gets in later in the pregnancy. And then the telephonic, that is something that we are really trying to evaluate. I know the agency is allowing some type of asynchronous or not face-to-face care to go on, even beyond the PHE being over. And we're just going to keep following and see if our fears are realized that people will abuse it. I don't believe that'll be the case. It hadn't been beforehand. But we just have to watch the data. But we have to understand that there are some challenges that this allows us to interact with vulnerable individuals and we need to try to make it work. Hope that answered all the questions.

[Lekisha Daniel-Robinson] I think you did. Thank you so, so much for doing so. And then there are a couple more questions. I'm going to try to condense them so that we can get answers. So, there was a question about how the states are doing with your prenatal visits and, you know, related to maternal outcomes. And then a related one, sort of related, I'm going to make it related, is that there are some -- did you address any concerns for patients who may have had a poor experience during labor and delivery and, therefore, did not return for postpartum care. So, kind of linking that prenatal period, obviously, labor and delivery with postpartum.

[Patricia W. Witherspoon] Prenatal -- and, again, that's -- I think we had such a high -- a 12-foot view, we believe that prenatal care is the first step to having good postpartum care. And, in our state, we were having -- and this was actually before COVID, was that how do we identify these women fast enough so that our MCOs, because we're an MCO-heavy state, that they know the women are pregnant. And we're still working through that. So, if we're not able to identify them, then they're not getting into care early. And then you have women that actually have made a decision for whatever reason not to enter care early. So, there are layers of layers of confounders that we will never probably have a full grasp of, but we're hoping to. And then back to the postpartum. That came out in anecdotal information that if they had a poor pregnancy relationship with the provider, and definitely if they had a poor delivery, like anyone, if you're not giving me the service, well, why on Earth would I go.

And that's [inaudible] that came out of some qualitative data that we got that from talking to women from one of our doulas. And, also, we had a major emphasis in looking at disparities. So, we had a Listening to Women program and they told us, "Why would I go back? It was not good. And I'm good now." Or, "I have competing challenges. I focused everything on getting this baby here. Now that the baby's here, I've got to go back to my laundry list of other competing demands." And that's the reality. And I think, as providers, we have to take more time to listen to or live in the reality that these women are if we truly want to try to help make their lives better. Because it's good lip service for us to say, "We want to make it better and they have the problem," but if we really want to, we will. And I think we're taking great steps in that because we're doing social determinants to health screens and that's allowing us to see if we don't address those, then we can't do the things that we're trained to do. And I'm sorry, but I get excited about this one.

[Lekisha Daniel-Robinson] We definitely appreciate your excitement about all of this effort, and what can be done around improving care for birthing and postpartum people. There's another question. I don't know if we can fit it in, but it's really about the value of learning collaboratives in terms of coaching and

experiences between states and PDSAs. I don't know if you have a 20-second response to that [inaudible] --

[Gloria Beecher] One quick response, very quickly. It's a very valuable endeavor. When we were not sure if we would [inaudible] second -- the second year, we reached out to Texas. It was because they had -- to find out why they were having such good outcome with keeping their providers engaged and we learned that. That's where we picked up our strategy to do one-on-ones with the CMOs, instead of doing joint meetings. And once we tested that, we saw almost instantly the difference it made to have sessions one on one with the CMOs. So, that's where we picked up value from this, as well as listening even to Dr. Witherspoon's presentation today, there are some things that we can pull back and take back to Georgia and begin to test and try. And I'm sure that others have benefited, too, in the same way.

[Patricia W. Witherspoon] Ditto, ditto. But if you live in a vacuum, you never know. And that's why, that's the value of collaboratives.

[Lekisha Daniel-Robinson] Well, thank you so much for that. And that offers a perfect segue to some of our closing items. So, as I mentioned earlier, CMS is committed and has committed resources to support Medicaid agencies and their partners to implement quality improvement projects. On Medicaid.gov, you will find some of these tools from driver diagrams to a getting started video. Currently, the topics available are asthma and tobacco cessation, but postpartum care is coming soon, along with some other topical areas. Next, please? Additionally, Medicaid and CHIP Quality Improvement Open School remains open. Folks just need to submit an Expression of Interest. If you have questions, the MAC Quality Improvement mailbox would be your best source of information at MACQualityImprovement@mathematica-mpr.com. I should have completed that. But through that resource, you have access to the Institute for Healthcare Improvements resource library, as well as more information about applying the Model for Improvement, which both Dr. Beecher and Dr. Witherspoon talked about as they were implementing their PDSA projects. Next, please?

And then, finally, the Medicaid and CHIP Quality Improvement office hours are available three times a month and, so, there's no need to sign up in advance, information is sent out. But if you have questions or you want to join the distribution list, MACQualityImprovement@mathematica-mpr.com would be the place to go for that. I wanted to thank you all for participating in the webinar and ask that you please complete the evaluation as you exit. We appreciate your feedback. And, again, this info will be used for the planning of future webinars, as well as other CMS activities. Thank you so much for joining.