

## Improving Postpartum Care: State Projects Conducted through the Postpartum Care Action Learning Series and Adult Medicaid Quality Grant Program

### Introduction

The postpartum visit provides an opportunity to assess women’s physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes or hypertension), mental health status (including postpartum depression), and family planning (including contraception and pre-pregnancy counseling). The visit is also an opportunity to counsel women on nutrition, breastfeeding, and other preventive health issues.

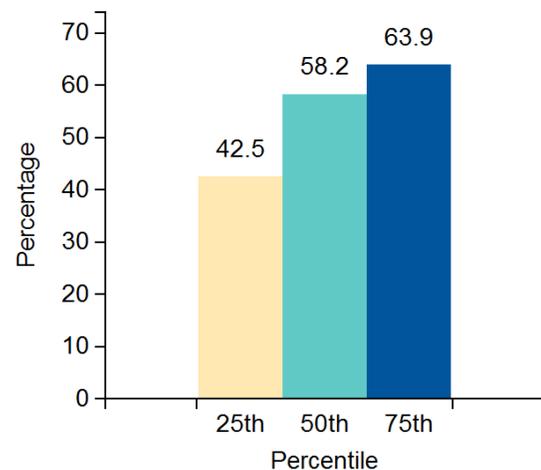
For this reason, improving the rate and content of postpartum visits were areas of focus for the Medicaid and the Children’s Health Insurance Program (CHIP) Maternal and Infant Health Initiative. To establish a baseline and monitor performance moving forward, the Center for Medicaid and CHIP Services (CMCS) added the Postpartum Care (PPC-AD) measure to the Medicaid Adult Core Set from the Core Set’s inception in 2013.

The postpartum care (PPC) visit rate ranged from 20 to 90 percent among the 34 states<sup>1</sup> using Adult Core Set specifications to report the measure for federal fiscal year (FFY) 2014. The median postpartum visit rate was 58 percent, with a 21-point spread between the 25th and 75th percentiles. As shown in Figure 1, there was substantial room for states to improve the PPC visit rate for Medicaid and CHIP beneficiaries.

In order to drive improvement on this measure, CMCS convened the Postpartum Care Action Learning Series (referred to as the Action Learning Series). The Action Learning Series was a structured, team-based collaborative learning experience which provided 10 states an opportunity to develop and implement quality improvement (QI) projects to improve postpartum care in Medicaid and CHIP. In addition, CMCS launched the

Adult Medicaid Quality Grant Program: Measuring and Improving the Quality of Care in Medicaid. This two-year grant program was designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Adult Core Set.

**Figure 1. Percentage of Women Enrolled in Medicaid and CHIP Who Delivered a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, FFY 2014 (n = 34 states)**



Source: Mathematica analysis of 2014 Adult Core Set reports.

The Action Learning Series and AMQ participant states implemented small tests of change to first identify and validate their proposed interventions. As such, these activities did not necessarily result in changes in statewide core set postpartum care measure rates. However, these projects gave states experience in undertaking QI activities and gave them valuable information on what strategies were and were not effective. States could then work toward spreading and scaling those small tests of change that demonstrated proof of concept. This fact sheet describes the QI teams

<sup>1</sup> The term “states” includes the 50 states and the District of Columbia.

in the 10 states, their aims, the interventions they tested, their results, and lessons learned. In addition, this fact sheet provides summaries of the postpartum care-related projects that four states undertook as Adult Medicaid Quality (AMQ) grantees.

## Summary of state QI strategies

States tested a variety of strategies to improve the PPC visit rate, the content of the visit, and access to effective contraception. Figure 2A (next page) displays a driver diagram representing the primary drivers (system components) and secondary drivers (activities) the states identified for improving the PPC visit rate. The primary drivers included: changes to payment and billing policies; team-based care using case managers, care coordinators, and community health workers (CHWs) to connect women to services such as transportation; beneficiary engagement using appointment reminders and education; and provider education about the importance of the PPC visit.

With regard to improving the content of the PPC visit, including increased access to effective methods of contraception, figure 2B (next page) displays a driver diagram representing the primary system components and activities states identified. The primary drivers included: payment policies; team-based and patient-centered care delivery models; provider and team member education; and beneficiary engagement through education.

The state profiles that follow describe the policy and program changes that the 14 states tested, results (if available), and next steps. The profiles also describe lessons states learned about implementing the QI process and about improving postpartum care in Medicaid and CHIP. At the conclusion of the Action Learning Series, several states planned to continue their efforts to improve postpartum care by aligning with other state QI activities, such as the infant mortality Collaborative Improvement & Innovation Network (CoIIN).<sup>2</sup> In addition, several states planned to continue their efforts to improve postpartum contraceptive care under CMCS's Maternal and Infant Health Initiative (MIHI) grant program.<sup>3</sup>

<sup>2</sup> The CoIIN to Reduce Infant Mortality is a public-private partnership to reduce infant mortality and improve birth outcomes. See <https://mchb.hrsa.gov/maternal-child-health-initiatives/collaborative-improvement-innovation-networks-coiins>.

## State profiles

### Alabama

**Team leaders:** Chris McInnish, Melinda Rowe—Alabama Medicaid Agency

**Partners:** Alabama Department of Public Health

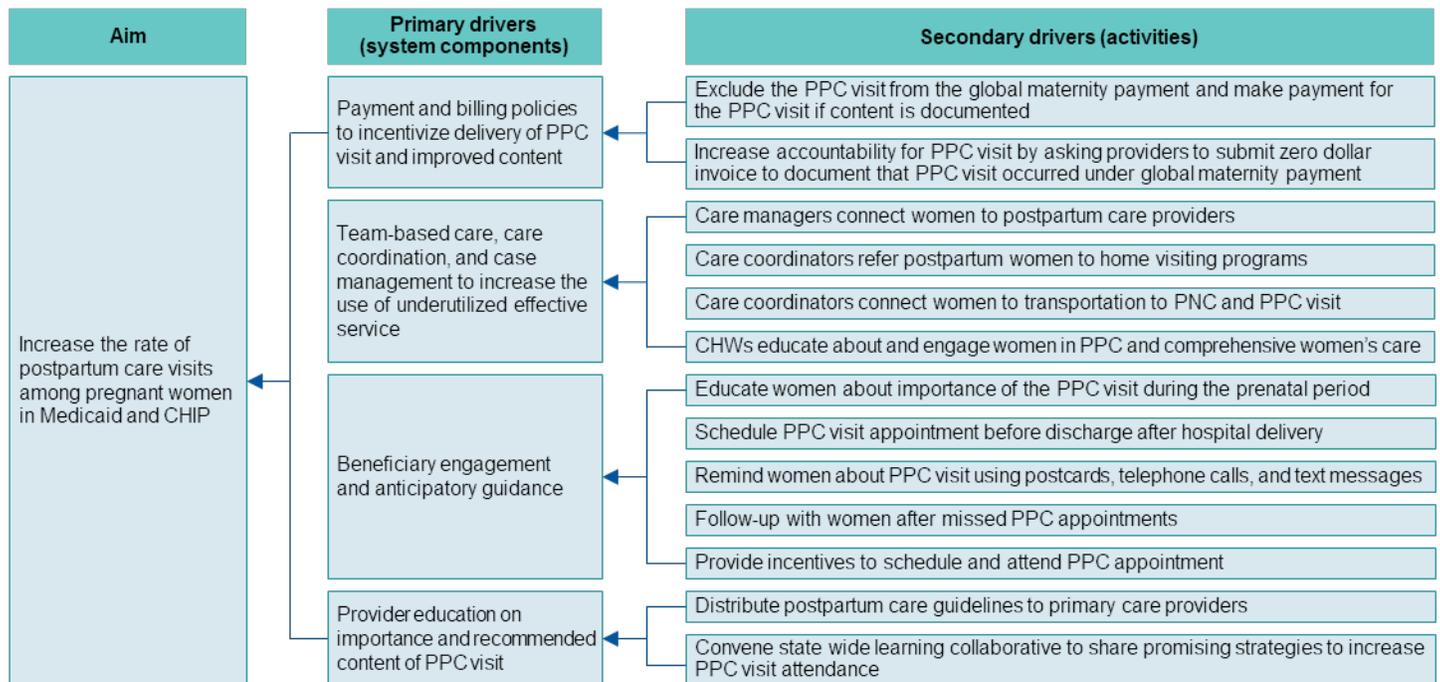
**Aim:** The specific aims related to PPC were: (1) to increase the PPC-AD rate from 76 to 78 percent; (2) to increase the percentage of postpartum women who participated in the Plan First Program (the state's Medicaid family planning waiver) from 34 to 36 percent; and (3) to increase to 45 percent the percentage of postpartum women who kept their primary care appointments.

**Project summary:** Medicaid beneficiaries who remained on Medicaid after the 60-day postpartum period and who had a current or previous adverse birth outcome were eligible for the project. Maternity care contractor case managers visited new mothers in the hospital before discharge to determine whether the mother met criteria for participation in enhanced interconception care (ICC) case management. Eligible women who agreed to participate were referred to case managers at the Alabama Department of Public Health (ADPH) who referred women and their infants to primary care providers for postpartum and well-child care. In addition, ADPH case managers distributed the Alabama Collaborative Improvement and Innovation Network to Reduce Infant Mortality ICC Guidelines to the mothers' primary care providers (389 physicians) from January 2013 to January 2015 to educate them on ICC including the postpartum visit.

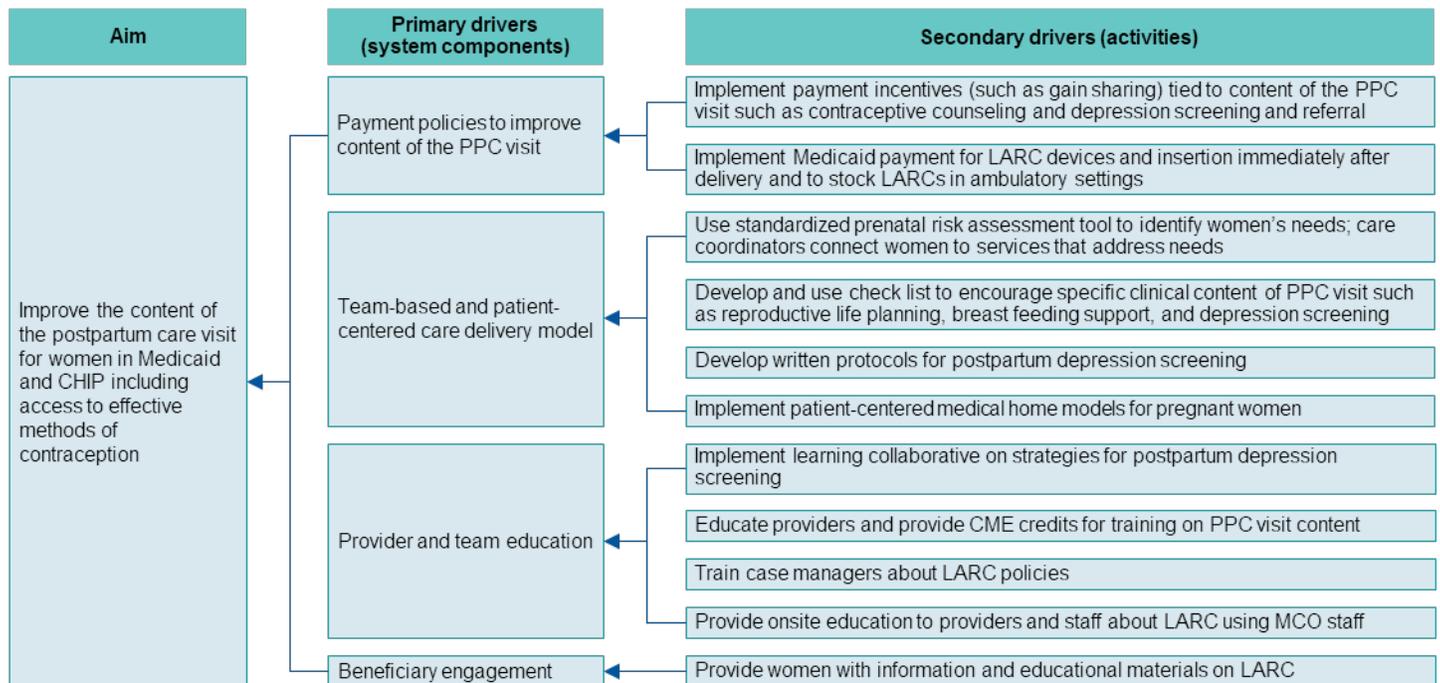
A total of 1,149 women were referred for ICC case management and ADPH case managers located 924 (80 percent) of the women. Of the 924 women, 673 (59 percent of those originally referred) agreed to receive ICC services. Of those who agreed to receive ICC services, 283 (42 percent of participants) had a PPC visit within 60 days postpartum. The percentage of postpartum beneficiaries participating in Plan First increased from 34 to 75 percent.

<sup>3</sup> More information about the MIHI grant program is available at <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/data-and-measurement/index.html>.

**Figure 2A. Aim and Key System Drivers and Activities to Improve the Rate of Postpartum Care Visits**



**Figure 2B. Aim and Key System Drivers and Activities to Improve the Content of the Postpartum Care Visit**



**Results:** The statewide PPC visit rate increased from 76 percent at baseline (FFY 2013) to 80 percent in March 2015.

**Lessons learned:** Adhering to strict eligibility criteria for inclusion in the intervention made it difficult to enroll a sufficient number of participants to assess the intervention's impact.

**Next steps:** Alabama planned to transition to Medicaid managed care and was developing 11 regional care organizations to deliver and manage care under a capitated payment system. A quality assurance advisory committee of providers, stakeholders, and researchers included the PPC-AD measure as one of the required quality measures regional care organizations must report. In addition, Alabama planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

## Arizona

**Team leader:** Kim Elliott—Arizona Health Care Cost Containment System (AHCCCS)

**Team members:** Jakenna Lebsock, quality leader; Laurene Kordell, data manager—AHCCCS

**Partners:** Mercy Care Plan; UnitedHealthcare; Robert Krauss, DO, obstetrician and medical director—Bridgeway Health Solutions; and private obstetrical practices

**Aim:** By July 2015, to have increased by 50 percent the rates of postpartum visits and provider–patient family planning discussions at the obstetrical practice with the largest Medicaid population in the state.

**Project summary:** The Arizona team tested several changes as part of the project, including: (1) adding a reminder call 72 hours before the PPC visit in addition to the existing reminder call 24 hours before the visit; (2) writing an order in the woman's hospital chart reminding the provider to remind the woman to schedule the PPC visit appointment; (3) distributing PPC visit reminder postcards to women after delivery; and (4) encouraging providers to use the teach-back method<sup>4</sup> to engage women in family planning discussions. All of the offices of the pilot site practice implemented the 72-hour reminder calls; the remaining interventions targeted five physicians from a geographic area where the postpartum visit compliance rate was low.

<sup>4</sup> Resources on the teach-back method are available at <http://www.ihl.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx>.

**Results:** The pilot site successfully implemented the 72-hour postpartum visit reminder, so that all postpartum women with scheduled appointments received either an electronic reminder (60 percent) or phone call from office staff (40 percent). Although the pilot site encouraged providers to write PPC visit orders in patients' records at the hospital, the pilot site was not able to evaluate how often orders were implemented, as providers reported that this practice was already standard. Similarly, in response to learning about the teach-back method to aid in family-planning discussions, providers reported that they already used a comparable method and felt it was helpful in communicating with patients.

At baseline (January 10 to April 2, 2014), 59 percent of women in the pilot site made a postpartum visit before the QI project started, and 54 percent made a postpartum visit during the second round of data collection (February 1 to April 1, 2015). The family-planning services discussion rate was 82 percent at baseline and remained the same at the second round of data collection.

**Lessons learned:** More time for follow-up is necessary to assess the full impact of the interventions. Data collection took longer than anticipated because the electronic health record did not capture all of the necessary data points and staff at the pilot site had to manually extract some data through chart reviews.

**Next steps:** The Arizona team planned to use the results from the QI project to facilitate discussions with health plans on ways to increase the PPC visit rate and on the effective use of contraceptive methods. The team also planned to focus on improving data collection and to continue assessing how to use data to initiate change to increase the PPC visit rate.

## California

**Team leader:** Julia Logan—Department of Health Care Services (DHCS)

**Team members:** Susannah Cohen, Vivian Szeto, and Sydney Armendariz—DHCS; Barbara Boehler—Communicare Health Centers

**Partners:** Communicare Health Centers; Petaluma Health Clinic; Marin County Clinic; California Department of Public Health; LA Care Health Plan; Health Net Partnership Health Plan; Text4baby;

California Maternal Quality Care Collaborative; California WIC Association

**Aim:** By December 31, 2015, to increase by 10 percent over baseline the postpartum visit rate in the pilot sites.

**Project summary:** The California team convened a statewide learning collaborative of key DHCS and Medicaid managed care plan staff including quality directors, medical directors, and health educators. The QI collaborative used regular, action-oriented teleconferences to share challenges and lessons learned, identify and resolve state and local barriers, and receive and provide technical assistance. One learning collaborative member, LA Care, shared a successful model, the Healthy Mom Postpartum Program, which was developed to address problems identified during a barrier analysis. The program components include scheduling assistance, transportation, interpreter services, and member incentives to attend the postpartum visit. The program served nearly 50 percent of potentially eligible women and participants had a postpartum visit rate of 76 percent in 2014.

**Results:** No results were available by the end of the project.

**Lessons learned:** It takes time to engage clinics and to tailor the pilot programs to the clinics' concerns and barriers. Collaboration was key to receiving clinics' buy-in. Incorporating feedback from clinic staff who work directly with Medi-Cal members was also important. Finally, the team learned that the clinics and managed care plans have competing priorities and limited resources for QI projects.

**Next steps:** The California team planned to conduct telephone interviews with new mothers who gave birth at a Communicare Health Center to ask them about their experiences with health care during and after pregnancy; their reasons for missing appointments and solutions to avoid missed appointments; their opinions on the value of PPC visits; and the effectiveness of incentives, such as gift cards and text message reminders, to encourage attendance at PPC visits. California planned to implement interventions at the state, managed care plan, and clinic levels. At the state level, DHCS planned to update PPC visit documentation policies regarding global billing and delivery notification procedures. Managed care plans also planned to update their documentation policies and conduct member outreach during the prenatal period. Clinics planned to conduct patient outreach and to educate patients about PPC visits and long-acting reversible contraceptives (LARCs). The

California team planned to test patient reminders early in the postpartum period. In addition, California planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

## Georgia

**Team leaders:** Janice Carson, Erika D. Lawrence—Georgia Department of Community Health (DCH)

**Team members:** Amerigroup Community Care; Georgia Regents University (GRU); Peach State Health Plan; WellCare of Georgia, Inc.

**Partners:** Amerigroup: Eagles Landing OBGYN Practice (ELOGA); GRU: GRU Women's Clinical Services; Peach State: Georgia Obstetrical and Gynecological Society and DeKalb Women's Specialist OBGYN Associates; WellCare: Grady Memorial Hospital

**Aims:** (1) By June 30, 2015, to increase by 10 percentage points over baseline the number of Medicaid and PeachCare for Kids women who had a postpartum visit within 21 to 56 days of delivery. (2) To increase by 20 percentage points the number of low-income women in their last trimester of pregnancy who engaged in a reproductive life plan discussion and selected immediate postpartum LARC insertion as their contraceptive method.

**Project summaries and results:** Each care management organization (CMO) focused on a high-volume provider to improve the PPC-AD visit rate. The projects were designed to determine whether provider and member education along with other interventions would improve the PPC-AD visit rate and effective contraceptive use. The approaches and progress varied across the four CMOs.

**Amerigroup project:** The Amerigroup pilot site provided prenatal education about the importance of PPC visits to members, educated providers about the postpartum care visit Healthcare Effectiveness Data and Information Set (HEDIS) guidelines, and provided office scheduling staff with financial incentives tied to women keeping their appointments.

**Amerigroup results:** At baseline (January 1 to December 31, 2013), the PPC-AD visit rate was 67 percent. After the interventions, in February, March, and April 2015, the rates were 78, 65, and 68 percent, respectively. A postpartum rapid-cycle performance improvement project was put in place at Amerigroup.

**GRU project:** The GRU pilot site educated patients about reproductive life planning and the PPC visit during the prenatal visits to test whether women would choose postpartum LARC insertions immediately following the reproductive life plan discussions. A delay in finalizing system configurations for hospital reimbursement of LARCs by DCH and the CMOs was a barrier to immediate postpartum insertion.

**GRU results:** GRU's baseline (June through December 2014) PPC visit rate was 58 percent; the rate from January to April 2015 was 54 percent. Staff noted that many of the patients sent to GRU for delivery received prenatal and PPC from other providers in the surrounding area. These women are included in GRU's denominator but might receive their PPC visits from another provider.

**WellCare project:** WellCare's pilot site initially focused on providing PPC visits in the patient's home, along with member and provider education. The site team experienced challenges obtaining data to determine the baseline PPC-AD visit rate, identifying members to participate, and holding regular planning meetings with stakeholders. WellCare could not implement a planned postpartum home health visit intervention because it could not secure a licensed provider or vendor to complete the specified elements of the visit in accordance with the standards. Instead, pilot site leadership and clinicians received education on the full HEDIS specifications and the difference between the PPC visit and the visit for an incision check.

**WellCare results:** This intervention resulted in a 4-point increase in the PPC care visit rate above the goal of 36.3 percent. As a next step, WellCare instituted a second intervention—to have pilot site clinicians educate members at 35 weeks gestation about the importance of the PPC visit and the difference between the PPC visit and a visit for an incision check.

**Peach State project:** Peach State identified a high-volume, low postpartum visit rate compliant provider to serve as the pilot site for its project. A proactive outreach manager called members to remind them to schedule their postpartum visits three to six weeks after delivery. The outreach manager offered assistance with scheduling, if needed. The calls were made seven days after a delivery, and data were collected to evaluate the effectiveness of the intervention.

**Peach State results:** No results were available by the end of the project.

**Lessons learned:** The pilot sites must be fully committed to the project and the defined goals. This commitment requires time, resources, and dedicated staff. The details must be discussed fully before confirming the pilot sites. Changes in pilot site personnel significantly affect the implementation and effectiveness of the project. Effective communication among the state, the CMO, and the pilot sites is essential to identify issues, discuss solutions, and offer assistance as necessary.

The Georgia team identified a unique issue in working with an academic site that requires institutional review board approval or a waiver from such approval to participate with state Medicaid agencies on QI projects. Because such approvals can be time-consuming, the team learned the importance of providing for enough lead time when implementing QI projects in academic settings.

**Next steps:** Georgia planned to continue the tests of change and to incorporate lessons learned into evidence-based practice. DCH and the CMOs planned to work together on messaging to clearly articulate the benefits and importance of increasing PPC-AD visit rates.

#### Iowa

**Team leaders:** Sally Nadolsky, Jason Kessler—Iowa Medicaid Enterprise (IME)

**Team members:** Stephanie Trusty, Diane Petsche, Debra Kane—Iowa Department of Public Health (IDPH)

**Partners:** March of Dimes, Iowa obstetrical providers

**Aim:** To assess the percentage of women with a Medicaid-reimbursed birth who received a postpartum visit within 56 days after the birth of her infant. In addition to validating IME's postpartum care visit rate, Iowa also assessed the content and quality of the postpartum visit.

**Project summary:** IDPH staff recruited three clinics based on the size of the clinics' Medicaid populations, their geographical locations, and their willingness to participate. IDPH worked with IME staff to identify clients who delivered infants from September 1 to November 30, 2014, and requested relevant paid claims data. IDPH staff developed a record audit tool to extract data regarding PPC visits and requested patients' records from each clinic. Staff completed abstractions for two clinics.

**Results:** At the first clinic, IDPH reviewed 12 charts and found 11 (92 percent) had a documented PPC visit. The postpartum visit occurred on average 45 days after delivery. At the second site, IME staff identified 48

women. However, 16, or one-third, did not have a medical record at the clinic. IDPH reviewed 32 charts and found a documented postpartum visit in 25 (78 percent) charts. The postpartum visit occurred on average 48 days after delivery (ranging from 4 to 130 days).

Abstraction of the medical records revealed (1) postpartum depression screening occurred for 67 percent of women at site 1 and only 22 percent at site 2; (2) domestic violence screening was completed for 58 percent of women at site 1 and for 81 percent at site 2; and (3) 67 percent of women at site 1 obtained contraceptives during the postpartum visit and 59 percent at site 2. Among those who obtained a contraceptive method, all women obtained a mostly or moderately effective method.<sup>5</sup>

**Lessons learned:** Testing and revising the chart abstraction tool was helpful in improving the method of using chart abstraction to learn about the content of postpartum care visits. Several women with serious medical and social risks sought a LARC at their PPC visits; however, due to clinic billing, scheduling, and informed consent issues, both sites asked the women to return to the clinic at a later date for LARC insertion. Although most of these women received a Depo-Provera contraceptive injection, barriers to LARC insertion at the postpartum visit present a risk for an unintended pregnancy if women fail to return for follow-up care. In reports to the clinics, the Iowa team encouraged staff to reexamine approaches to the billing, scheduling, and informed consent issues, so that LARC methods can be placed at the postpartum visit.

**Next steps:** The Iowa team prepared and submitted reports to the clinic sites where they completed record abstractions. In the reports, Iowa emphasized the high proportion of women who received a postpartum visit and urged clinics to review policies that created barriers to receipt of contraceptive methods at women's postpartum visits. The Iowa team planned to complete a review of the records from a third clinic. The team was planning to align the completed work and future activities to support work in the infant mortality CoIIN with a focus on immediate postpartum LARC insertion and reproductive life planning. In addition, Iowa planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

<sup>5</sup> For a description of the effectiveness of contraceptive methods, see [http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/Contraceptive\\_methods\\_508.pdf](http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/PDF/Contraceptive_methods_508.pdf).

## Louisiana

**Team leaders:** Rebekah Gee, medical director—Louisiana Medicaid; Joan Wightkin, assistant professor—Louisiana State University (LSU), School of Public Health

**Team member:** Ekwutosi Okoroh, epidemiologist assignee—Louisiana Medicaid

**Partners:** Angela Olden, Quality Management & Performance—LA United Healthcare; Ann Kay Lagarbo, medical director—United Healthcare; Michael Perniciaro—OB pilot site provider; Sandy Schoeffler—pilot site office manager; Lanique Roussell, quality management director, and Marcus Wallace, medical director—Amerigroup Louisiana; Dawn Ruiz—pilot site office manager

**Aim:** By July 2015, to (1) end Medicaid global billing for deliveries that include the postpartum visit; and (2) test the improvement of the content of PPC in pilot sites as measured by the number of checklists filled out and percentage of items on checklists completed by the pilot site for LARCs and other contraception, birth spacing counseling, depression screening with an evidence-based tool, referral to primary care provider, and obstetric risk assessment sent to managed care organization (MCO) case managers.

**Project summary:** To improve the content of the PPC visit, Louisiana developed a PPC checklist with input from the LSU Department of OB/GYN, a private OB practice management company, federally qualified health centers (FQHCs) implementing an interpregnancy care improvement project, and the PPC Action Learning Series technical assistance team. With engagement by two Medicaid MCOs, the Louisiana team identified two pilot sites that in May and June 2015 tested the use of the checklist for one week. One pilot site continued to collect data for a few weeks. The second pilot site ended the testing after seven days due to the added burden of the Patient Health Questionnaire (PHQ9) depression screen. The QI team discussed findings and next steps with each of the plan's case management directors and with Medicaid MCO medical directors. Louisiana ended global billing for deliveries in June 2015 and implemented a separate postpartum visit billing policy.

**Results:** The checklists showed that providers assessed women for chronic conditions and counseled them about

contraceptives and birth spacing. The checklists indicated LARC insertion in 5 percent of women and that LARC was planned or ordered in another 10 percent. Seventy percent of completed checklists showed that women had no primary care providers, and only 10 percent were referred to primary care. All checklists showed depression screening with Edinburgh Postpartum or PHQ9 tools, with 15 percent having positive findings. The field for risk assessment for case management services from the Medicaid MCOs was often blank. The state planned to track postpartum visits using the hybrid PPC-AD measure for a year following the June 2015 policy change.

**Lessons learned:** The Louisiana team found the electronic medical records (EMRs) used in the pilot sites included many of the chronic condition and contraception items that were on the checklist. The team also learned that obstetrics providers and staff did not refer women for primary care following the postpartum period and had great difficulty finding mental health resources for women with depression and other mental disorders. Each Medicaid MCO required providers to use a different form to refer patients to case management services, and providers were often confused about or unaware of these services.

MCOs that used a pharmacy for ordering LARCs might not have had the LARC available at the time of the postpartum visit and scheduled women for a subsequent appointment for LARC insertion. The LARC was wasted when patients did not keep their scheduled appointments.

**Next steps:** The Louisiana team planned to meet with each MCO case management director to review postpartum outreach and case management processes for (1) care transition to primary care at FQHCs for women who lose coverage after the postpartum period, (2) transition to family planning Medicaid coverage, and (3) contraceptive counseling to add information on the most effective methods. The team planned to consider options to better support obstetrics providers and staff in finding mental health resources for women with depression and other mental health disorders. It also planned to work with MCO practice consultants to educate providers on LARC effectiveness and ordering processes. The team planned to review each MCO's LARC ordering policies to facilitate providers' stocking of LARCs and to work with MCOs to remove barriers.

<sup>6</sup> Text4baby is a free mobile health program that delivers health information to pregnant women and new mothers through text messaging. See <https://www.text4baby.org/> for more information.

## Massachusetts

**Team leaders:** John Boney, Ann Lawthers, Jillian Richard-Daniels, Gladys Ting, Rossana Valencia-Hoang—MassHealth Quality Office

**Partners:** University of Massachusetts Medical School; Massachusetts Department of Public Health; the Center for Health Impact (formerly the Central Massachusetts Area Education Center); Voxiva (Text4baby)

**Aim:** To exceed the national 2014 Medicaid HEDIS 75th percentile rate of 71 percent for PPC-AD.

**Project summary:** The Massachusetts project included three components: (1) educating MassHealth (Massachusetts Medicaid) perinatal providers about the importance of PPC visits using a MassHealth email bulletin; (2) training community health workers (CHWs) about interconception care, with an emphasis on PPC; and (3) collaborating with Text4baby<sup>6</sup> to promote the PPC visit. Information in the MassHealth email bulletin emphasized the providers' role in promoting and encouraging beneficiaries to attend the PPC visit, clarified the timing and requirements of the visit for the PPC-AD measure, and suggested possible strategies to increase the PPC-AD visit rate. MassHealth offered free 18-hour CHW trainings statewide, in collaboration with the Center for Health Impact, to increase CHWs' knowledge of interconception care, including how to provide education and promote the importance of the PPC visits, coordinate access to services, and advocate for women's health interventions. Finally, the team worked with Text4baby to customize message content about the availability of health-related services in Massachusetts and to encourage participants who self-identified as MassHealth beneficiaries to attend their PPC visits through targeted messaging.

**Results:** Massachusetts achieved a weighted mean of 69.3 percent for PPC-AD in 2014 (compared with the 2010 weighted mean of 68.7 percent). The team could not evaluate the effectiveness of the provider bulletin due to the low participation in a provider survey. About 90 people from community health centers, community-based organizations, and MCOs participated in the CHW trainings. Participants rated the quality of the trainings very highly, with an average score of 4.8 on a 5-point scale. Most participants used the information and felt they gained a significant amount of knowledge, as indicated by follow-up surveys, pre- and post-knowledge

tests, and qualitative interviews with a subset of participants. Self-identified MassHealth beneficiaries were asked via the Text4baby application about their use of and satisfaction with the app. Preliminary results showed high acceptance and satisfaction with Text4baby among MassHealth beneficiaries and they remained enrolled longer than other Massachusetts Text4baby participants. Massachusetts tracked the number of women who replied to a text message asking whether they would attend their PPC visits and the number of Text4baby appointment reminders requested by participating women. At three weeks postpartum, 84 percent of participants reported they planned to attend the PPC visit; only 7 percent of those who had not yet attended the PPC visit did not plan to attend. At nine weeks, 77 percent of women reported they had attended a PPC visit and 13 percent reported they did not plan to attend the visit. When respondents reported they did not plan to attend due to transportation issues, they received a text message about how to arrange for transportation covered by MassHealth.

**Lessons learned:** Massachusetts experienced delays in starting the project due to long internal review and approval processes, limited resources and staff time, and the need to secure funding for the interventions. The state also experienced difficulties in aligning its efforts with MCOs that were already required by their state contracts to improve PPC-AD rates. As a result, Massachusetts increased efforts to ensure buy-in and input from the MCOs and to learn about ongoing MCO-led projects. Participation in the CHW training was lower than expected, possibly due to a lack of incentives or penalties tied to attendance. CHWs often did not have the leverage they needed to facilitate collaboration with providers on PPC efforts. Finally, at midcourse, Text4baby changed the time frame for the follow-up survey from seven to nine weeks postpartum to better align with the PPC-AD measure, so MassHealth could not use data from the earlier period.

**Next steps:** The Massachusetts team planned to share the CHW training curriculum with MCOs to promote further understanding of the value of the postpartum visit and key components. They planned to encourage MCOs to distribute the curriculum to staff and providers and even conduct trainings themselves. In addition, Massachusetts planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

## Michigan

**Team leader:** Meta Kreiner—Michigan Department of Health and Human Services (MDHHS)

**Team members:** Rachel Copeland, Monica Kwasnik—MDHHS

**Partners:** Medicaid Health Plans: Meridian Health Plan of Michigan, Harbor Health Plan, HAP Midwest Health Plan, and Blue Cross Complete (and their associated clinical site partners); Debra Darling—Institute for Health Policy, Michigan State University; Barbara Derman—MDHHS Population Health and Community Service Administration, Division of Family and Community Health

**Aim:** By September 2015, to improve by 30 percent or more PPC-AD visit rates in pilot sites among women who are due for a postpartum visit from May to September. Ninety percent or more of women between the last month of pregnancy and three weeks postpartum at the pilot sites will have a transportation needs assessment via telephone and a home visitation referral by a care coordinator.

**Project summary:** Michigan's project used a health equity focus, identifying racial or ethnic disparities in the PPC visit rate and identifying strategies to improve health equity. Michigan recruited 4 of 13 Medicaid health plans in December 2014, and MCOs or clinical sites implemented enhanced care coordination and transportation benefit interventions in May 2015. The Michigan team adapted the PPC Action Learning Series tests of change worksheet for health plans to use as tools to prepare for data collection for transportation and care coordination interventions. For example, the transportation worksheet prompted plans to consider how the health plan, pilot clinics, and maternal infant health programs would refer patients for transportation scheduling assistance and how to track the transportation services. Interventions developed from the pilot included a home visitation information sheet for providers and another for patients, and a template for health plans to complete and distribute to providers. The template included fields for telephone numbers and information on coverage and prior authorization for topics on the PPC visit checklist, such as breastfeeding, transportation, smoking cessation, and depression screening.

**Results:** Pilot interventions started on May 1, 2015. As of October 2015, three participating Medicaid health plans had submitted complete pilot data. For the 74 women included in the pilot from the three Medicaid health plans, results indicated an 84 percent postpartum visit rate (range of 73 to 87 percent).

**Lessons learned:** Michigan was successful in using preliminary data on PPC-AD visit rates as a tool to recruit health plans, by providing each health plan with preliminary data on the racial or ethnic disparity in its PPC visit rate and a graphical display of how the plan compared with other plans. More plans than expected volunteered for the QI project.

Project planning discussions and monthly project calls identified additional postpartum issues to address within the pilot project and in the future. The team identified a need for greater postpartum depression screening support, because many patients face a range of behavioral health challenges. The team is also considering partnering with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), because discussions have indicated a need for greater support for breastfeeding, especially for teen mothers. Finally, discussions have highlighted that many patients have multiple health needs outside of reproductive health, so it is important to transition women to primary care during the postpartum period.

**Next steps:** Michigan State University planned to conduct interviews with a subset of the postpartum women and to analyze the pilot data not only for the postpartum visit rate, but also for use of the transportation benefit, use of the home visitation program, rates of immediate postpartum and primary care transition outreach, and breastfeeding rates. Michigan posted new home visitation information sheets online and was considering a future pilot project focused on breastfeeding. The new Medicaid managed care contract that started January 1, 2016, provided a platform for spreading changes. The proposed statement of work included a greater focus on addressing health disparities and social determinants of health, further integration of the home visitation program with health plans, attention to car seats and allowing additional riders when appropriate as part of the transportation benefit, removal of prior authorization for contraception, and a common Medicaid formulary. In addition, Michigan planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

## Minnesota

**Team leaders:** Tessa Wetjen, Susan Castellano—Minnesota Department of Health (MDH)

**Partners:** 13 pediatric and family medicine clinics

**Aim:** (1) To increase to 100 percent the percentage of mothers receiving a universal postpartum depression (PPD) screening at the pilot sites; and (2) to increase to 100 percent the percentage of mothers receiving an intervention, such as education, support, or referral to another provider for PPD treatment after screening positive for PPD at the well-child visit.

**Project summary:** The Minnesota team supported 13 clinics throughout the state in developing a standard clinical PPD screening protocol. The workflow protocols were designed to screen for and appropriately refer patients for PPD treatment during a well-child visit. The team provided individualized technical assistance to clinic staff, developed materials to aid implementation, and established a learning collaborative. The learning collaborative addressed training on PPD, the Institute for Healthcare Improvement Model for Improvement, and PPD referral options in the community. Learning collaborative participants received continuing medical education credits. To guide implementation MDH contracted with ACET, Inc. to create clinic-specific monthly feedback reports on screenings and referrals. A work group consisting of physicians, advocates, state public health staff, and others working with the target population was established to guide the project and share lessons learned on PPD screening and managing PPD screening results, and culminated in publication of written guidelines for implementation.

**Results:** The monthly survey reports revealed low referral rates for women who screened positive for PPD in some clinics, which helped these providers recognize they had to improve referrals. The feedback report data also highlighted the need for provider trainings, as some providers were not responding to the screens appropriately. Therefore MDH conducted additional, targeted trainings. These trainings helped providers understand the urgency for action and the ease of making referrals. Using feedback from clinic teams and the advisory work group, MDH learned that scripts could be helpful. It developed scripts and shared them with clinics to use as needed. At the end of the learning collaborative, all the clinics had successfully implemented universal screening and referrals. Overall, the providers indicated that the time it added to their appointments was negligible and when it took more time to address a positive screen, the opportunity to address the concern was worth the extra time.

**Lessons learned:** Clinics were reluctant to commit to the QI project due to the time involved in developing and implementing the new workflow protocols for PPD screenings and referrals. Although the clinics swiftly implemented the PPD screenings, providers did not adequately follow through with the referrals or other interventions without additional support and training. Some clinics were reluctant to screen without a clear process for documenting the screenings and results. Project staff developed a work aid to help clinics choose a documentation method. Finally, some pediatric clinic providers were displeased with the PPD treatment women received after they were referred for positive screens, which led to them altering their referrals.

**Next steps:** The MDH planned to support the spread of screening and referrals for PPD using tools developed in this project.

### Mississippi

**Team leader:** Christy Lyle—Mississippi Division of Medicaid (DOM)

**Team members:** Roxanne Coulter, Geraldine Bethley, Mary Katherine Ulmer, Pequita Fields, Marilyn Dickerson—DOM

**Partners:** Jeremy Erwin and Carrie Mitchell—Magnolia Health; David Williams, Reesheda Rhymes, and Diane Bennett—UnitedHealthcare Community Plan

**Aim:** By July 2015, to improve by 50 percent (from 62 percent to 90 percent) the rate of postpartum visits occurring from the 21st to the 56th day among postpartum women in the pilot sites and increase by 25 percent the postpartum use of effective contraceptives begun within the 21st and 56th days postpartum for women in the pilot sites covered under the Mississippi Managed Care Program coordinated care organizations (CCOs) (Magnolia Health and United Healthcare Community Plan Mississippi) or traditional fee for service.

**Project summary:** Mississippi's interventions spanned the prenatal and postpartum periods. The Mississippi team provided clinics with educational materials on effective contraceptives (especially LARCs), to distribute to pregnant members. CCO care managers provided members with education on PPC visits and contraceptives (LARCs), scheduling or rescheduling assistance, and reminders. CCO specialists visited the pilot sites and educated providers on Medicaid beneficiary birth rates and effective contraceptives (LARCs) given immediately post-delivery or during the PPC visit. CCO clinical consultants also

educated billing and coding specialists about the importance of billing for the PPC visit for tracking (even though the claims will be denied due to the global fee).

**Results:** At pilot site A, the baseline (November 2013 to July 2014) PPC-AD visit rate was 0 percent (0 PPC visits and 234 deliveries) based on administrative data; no LARCs were inserted. The PPC-AD visit rate during the project period (November 2014 to April 2015) was 79 percent (27 PPC visits and 34 deliveries). Nearly all patients (24 patients and 27 visits or 89 percent) accepted contraceptives during the PPC visit. Two chose LARCs. At pilot site B, the baseline PPC-AD visit rate was 0 percent (0 PPC visits and 133 deliveries); two claims were filed for LARCs. The PPC-AD visit rate during the project period was 22 percent (31 PPC visits and 141 deliveries). Five women refused contraceptives, 22 women accepted contraceptives during the postpartum visits, and 10 women received contraceptives immediately post-delivery.

**Lessons learned:** In many cases, the low rate of postpartum visits reflects the lack of a filed claim. The team believes that practitioners could make an effort to ensure that patients return for the postpartum visit if Medicaid is able to unbundle the global payment for prenatal care, delivery, and PPC. In addition, medical record documentation of the postpartum visit appears to be routine due to the use of templates in the EMR and that the EMRs do not include the quality of care issues that have to be covered at the postpartum visit. It is important to have the full engagement of the provider clinic to improve postpartum visit rates and the use of contraceptives, especially LARCs.

**Next steps:** The Mississippi team planned to propose a change in Medicaid policy to eliminate the postpartum visit from global billing and bill the postpartum visit separately. The team also planned to develop training materials for providers on the importance of (1) providing contraception counseling during the pre-conception and post-delivery periods and (2) documenting patient education related to contraceptives. It also planned to develop approaches to compensating hospitals and/or practitioners to provide LARCs immediately post-delivery. Both CCOs were planning to evaluate physician incentive programs to increase the rate of PPC visits from 21 to 56 days postpartum. They also were planning to consider implementing the interventions at other sites, especially FQHCs. In addition, Mississippi planned to collect and report data and assess progress on postpartum contraceptive care under the MIHI grant program.

## North Carolina

**Team leaders:** Kate Berrien—Community Care of North Carolina (CCNC); Thomas George—Division of Medical Assistance (DMA)

**Team members:** Tonita Hamilton, Terri Pennington, Andrea Phillips—DMA; Alvina Long, Dara Dockery—Division of Public Health (DPH); Angel Huneycutt, Amy Jensen, Julie Lovingood, Betty Mazzeo, Doris Robinson, Lisa Tucker—CCNC

**Partners:** DPH; DMA; and CCNC (including five local networks: CC Partners of Greater Mecklenburg, CC of the Lower Cape Fear, CC of Wake and Johnston Counties, CC of Western NC, Community Health Partners)

**Aim:** (1) To increase the number of Medicaid patients who have a postpartum visit within 60 days of delivery; and (2) to increase postpartum contraceptive use, including use of LARCs, within 60 days of delivery.

**Project summary:** CCNC local networks recruited seven sites from 390 practices participating in North Carolina’s Pregnancy Medical Home (PMH) program. The PMH program engages maternity providers in a data-driven population health model aimed at improving birth outcomes, improving quality of care, and reducing health care costs in the pregnant Medicaid population. Sites included large, hospital-affiliated high-risk obstetrics clinics; private practices; and county health department maternity clinics. The obstetrics nurse coordinator from each site’s local CCNC network provided leadership and support. Each site was encouraged to select its own changes to test. The strategies are described in the results section.

At the conclusion of the Action Learning Series, three sites considered their projects complete and entered the maintenance phase. They worked to resolve additional issues identified during the project implementation. One site did not complete data collection or tests of change due to staff turnover and a move to another building. The remaining sites continued to work on QI projects.

**Results:** Pilot site A implemented the intervention of reminder phone calls, reminders by all clinic team staff who interact with a patient (for example, WIC), and the protocol of scheduling two visits—one at two weeks postpartum and one at six weeks. Under the intervention implemented at pilot site A, the postpartum visit rate increased from 67 to 89 percent.

Pilot site B tested the intervention of scheduling the postpartum visit at 21 days postpartum, scheduling the appointment before hospital discharge, conducting phone outreach, and providing care management support. Under the intervention implemented at pilot site B, the postpartum visit rate increased from 68 to 76 percent.

Pilot site C implemented the intervention of reminder phone calls and outreach to patients for missed appointments. The site saw the PPC visit rate increase from a baseline of 80 percent to a rate of 89 percent at the end of the project.

**Lessons learned:** North Carolina’s QI project highlighted the importance of committed QI leadership and strong, ongoing support to increase the effectiveness of these interventions and to affect postpartum visit rates. Two of the three sites with completed projects had QI teams in place at the start of the project and all had access to data and data support. The QI project also revealed system issues. One clinic scheduled postpartum visits more than six weeks after a woman’s delivery due to a lack of capacity, often leading to missed appointments. Long wait times prevented many clinics from quickly rescheduling those missed appointments. Finally, this project identified several PPC transition issues. Nearly 25 percent of North Carolina Medicaid patients received maternity care from a practice that does not offer delivery services; some of these patients slipped through the cracks as they transitioned across various settings and providers for antepartum, intrapartum, and postpartum care.

**Next steps:** North Carolina planned to continue supporting pilot sites and to spread these interventions and strategies more broadly across the PMH community. The team also planned a postpartum-focused QI project at 20 to 30 PMH practices, along with efforts to disseminate the PMH Care Pathway on Postpartum Care and the Transition to Well Woman Care. (PMH Care Pathways are clinical guidance documents that establish expectations for best practice care among all PMH providers.) North Carolina’s goal was to establish clear criteria for determining who will provide PPC for the 25 percent of Medicaid women whose newborns are not delivered by their prenatal care providers and to focus on improving communication among care providers. Finally, North Carolina planned to use the QI approach to address other priorities, such as improved management of patients with hypertensive disorders of pregnancy.

## Ohio

**Team leaders:** Jonathan Barley, Melissa Nance—Ohio Department of Medicaid;

**Team members:** All five statewide Medicaid managed care plans (MCPs) and, in Hamilton County, the University of Cincinnati (UC) Medical Center, the UC Obstetric Clinic (Hoxworth Center), and five outlying UC obstetric clinics

**Partners:** Health Services Advisory Group (HSAG)

**Aim:** By December 2015, to (1) increase the percentage of beneficiaries at the UC partner site who attend their PPC visits within 0 to 90 days after delivery from 33.0 to 49.5 percent; (2) increase the percentage who receive family and contraceptive planning services by 10 percent (from 36.6 to 40.2 percent); (3) increase the percentage who receive a breastfeeding evaluation by 10 percent (from 19 to 20.9 percent); (4) increase the percentage screened for depression by 10 percent (from 23.4 to 25.8 percent); and (5) increase the percentage of beneficiaries with gestational diabetes who receive glucose screening from 0 to 10 percent. (Note: Baseline percentages are from February 2014).

**Project summary:** Ohio's project focused on perinatal care management. At a beneficiary's first prenatal visit, the UC obstetric clinic completed a prenatal risk-assessment form. The results were shared with the MCP care manager, who contacted the beneficiary to promote the MCP perinatal incentive program and encourage enrollment. In parallel, the UC clinic case manager counseled high-risk beneficiaries on the importance of perinatal health care and the MCPs' incentives and programs, which typically include rewards such as gift cards or baby items for attending prenatal, postpartum, and well-baby visits. After delivery, UC case managers ordered a home health visit and scheduled postpartum and well-child visits for the new mothers and their infants and informed MCP care managers of the deliveries and the beneficiaries' discharge plans. The UC case manager followed up with beneficiaries when they missed their PPC visits. The MCP care managers contacted the mother before discharge to build rapport, identify barriers, and connect her with care management if she was not already connected. The MCP care managers also contacted the mother following discharge to confirm she attended the PPC visit and to offer rescheduling assistance if needed. The home health agency provided information about the home visit to the MCP care manager.

The MCPs worked with the transportation companies to ensure booster seats and car seats were available to mothers and made referrals to local child care resources when needed.

Ohio routinely monitored its data and refined its interventions. HSAG conducted three focus groups with 11 pregnant women and 4 postpartum women in August 2014 and used the results to add and refine interventions to increase beneficiaries' awareness of perinatal financial incentives, assist them in identifying affordable and convenient child care, and ensure transportation companies provided booster and car seats. MCPs were not able to assess the level of and changes in patient activation, due to low response rates and high attrition rates.

**Results:** From February 2014 to February 2015, the percentage of Hamilton County female beneficiaries who attended the postpartum visit within 90 days increased from 33.0 to 55.7 percent; the percentage that received family and contraceptive planning services increased from 36.6 to 98.2 percent; the percentage that received a breastfeeding evaluation increased from 19.0 to 93.8 percent; and the percentage who were screened for depression increased from 23.4 to 100.0 percent. One woman was identified with gestational diabetes and was referred for follow-up.

**Lessons learned:** Ohio experienced challenges from the beginning of the project onward. Initially, there were delays in launching the project due to the transition to a new Medicaid information technology system, which affected data access, and the need for new partnerships and processes to be established in a part of state government being unaccustomed to working collaboratively on improvement projects with Medicaid or its MCPs. There were challenges to addressing the many social determinants of health, making the need to build rapport and develop trust with provider sites paramount. Rapport and trust-building were addressed through initial biweekly meetings and site visits when possible. Because previous improvement efforts focused more on compliance and assurance, the MCPs and HSAG found it challenging to incorporate QI science principles. This challenge was mitigated through intensive and ongoing technical assistance with partners. Care managers also experienced implementation challenges. Lack of trust and rapport between the beneficiaries and MCP care managers hindered outreach efforts. Care managers reported additional barriers such as invalid phone numbers, unanswered calls, and lack of cell phone plan minutes. Some MCPs struggled to invest

in their QI projects because the UC partner sites did not serve a large number of their beneficiaries. In January 2015, MCPs were allowed to partner with additional clinics that treated more MCP beneficiaries. Despite this change, one MCP discontinued its QI project.

**Next steps:** The Ohio QI team brought attention to the needs of women of reproductive age and the importance of not losing track of high-risk women. Ohio planned to incorporate the postpartum visit measure into major value-based purchasing efforts, including episodes of care and the patient-centered medical home (PCMH) model. As part of the perinatal episode of care, the postpartum visit must occur in order for the provider to participate in gain sharing. In addition, the postpartum visit was incorporated into the PCMH model as a performance measure. At the MCP level, performance was being encouraged through enhanced maternal care guidelines and pay for performance, where plans have the opportunity to earn bonus payments by achieving high rates of performance on key measures, including postpartum visits. Ohio also planned to redesign its care management program to provide additional supports for high-risk women.

## Oklahoma

**Team leaders:** Shelly Patterson, director—Office of Health Promotion, Oklahoma Health Care Authority (OHCA); Daryn Kirkpatrick, director—Office of Creative Media and Design, OHCA

**Team members:** Paul Patrick, program manager and data manager—Maternal and Child Health (MCH) Assessment, Oklahoma State Department of Health (OSDH); Joyce Marshall, director and quality leader—MCH Service; Jill Nobles Botkin, program manager and quality leader—MCH Service, OSDH

**Partners:** Patricia Wallace Edmond, care manager coordinator/health educator; Yolanda Viewins, care manager—Central Oklahoma Healthy Start (COHS)

**Aim:** By July 2015, to increase by 30 percent (from 21.1 to 27.4 percent) the PPC visit rate and improve the content of visits provided by COHS among pregnant and postpartum women covered by SoonerCare and engaged in COHS.

**Project summary:** Oklahoma planned to partner with a state university clinic that provides care to the largest number of high-risk, low-income pregnant women in the state. However, due to staff turnover, implementation at the clinic did not occur. The team instead defined the

target population to include all pregnant and postpartum women included in the COHS program. COHS care managers attended trainings on SoonerCare LARC policy, infant safe-sleep best practices, breastfeeding, and SoonerCare enrollment and benefits. Interventions included active engagement and enrollment of pregnant and postpartum women into COHS and improved content of COHS visits (with a special focus on postpartum visit attendance and on LARC and other effective contraceptives). The Oklahoma team created a PPC brochure and tested it on 15 participants. The brochure was well received; the team has disseminated the brochure to all COHS participants. Oklahoma also tested incentives such as smoking cessation “quit kits,” well-child calendars, baby books, and growth charts to actively engage women in COHS services. The incentives were also well received; the Oklahoma team scaled up this intervention and spread it to all participants in education classes.

**Results:** The baseline (October 2014 to January 2015) PPC visit rate was 67 percent (12 of 18 eligible women). During the project period (February 2015 to May 2015), the postpartum care visit rate was 87 percent (7 of 8 eligible women). Intrauterine device rates increased from 17 percent (3 of 18 eligible women) to 25 percent (2 of 8 eligible women). Breastfeeding rates remained the same at the second round of data collection (100 percent).

**Lessons learned:** Oklahoma indicated that its QI project was a great opportunity for OHCA/OSDH and COHS to collaborate and become more familiar with the programs administered by each organization. The team learned that only some providers were willing to schedule the PPC visit before delivery, preventing case managers from helping all women with early scheduling. In addition to process-related lessons learned, the team learned that lack of health insurance coverage for some women during the postpartum period was a barrier.

**Next steps:** COHS case managers planned to sustain efforts to promote PPC visits and the use of LARCs and other effective contraception. OSDH, COHS, and OHCA planned to continue their collaboration on efforts to improve the PPC visit. The Oklahoma team was also working on a contract with the state university clinic to provide COHS services on site, as originally planned. The team planned to transition some of these efforts into the Preconception and Interconception CoIIN project. It also planned to move toward implementing targeted QI initiatives for providers.

## West Virginia

**Team leader:** Tanya Cyrus—Bureau for Medical Services (BMS)

**Team members:** Tim DeBarr, Leon Smith—BMS; Cynthia Taylor—BerryDunn Consulting

**Partners:** Three managed care organizations, three hospitals, and seven physician offices

**Aim:** By July 2016, to increase the PPC visit rates among women 18 and older by 5 percentage points at seven provider pilot sites affiliated with three hospitals, and statewide by 5 percentage points.

**Project summary:** West Virginia’s seven physician offices distributed non-emergency medical transportation brochures to Medicaid women at all stages of their pregnancies. West Virginia held weekly calls with pilot physician offices to discuss measurements that reflect the distribution of the brochure. West Virginia developed a Microsoft Excel spreadsheet for one pilot site to capture two weeks of transportation data.

**Results:** Weekly calls with physician offices established that patients were using non-emergency medical transportation benefits for their appointments. The team worked with one site to collect two weeks of transportation and postpartum visit data to measure the effectiveness of the distribution of the transportation brochure intervention. The team also requested data from MCOs to measure changes accurately.

**Lessons learned:** West Virginia learned that planning is important, and some results can take longer than expected. Collaboration with MCOs and the external quality review organization is important throughout the process.

**Next steps:** West Virginia planned to use contracts with MCOs and its external quality review organization vendor to implement PPC QI projects for all MCO providers. West Virginia’s overall plan was to continue to explore transportation assistance as a potential intervention, and to make resources available to MCOs for statewide implementation and utilization. Finally, West Virginia added a “Quality Corner” to the quarterly provider newsletter to highlight quality initiatives.

## For More Information

If you have questions about the projects or to obtain technical assistance with collecting, reporting, and using the Child and Adult Core Set measures, please contact [MACQualityTA@cms.hhs.gov](mailto:MACQualityTA@cms.hhs.gov).