Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health Quality Improvement

QUALITY IMPROVEMENT AFFINITY GROUP HIGHLIGHTS

June 2024

Highlights from the Improving Infant Well-Child Visits Affinity Group

Background

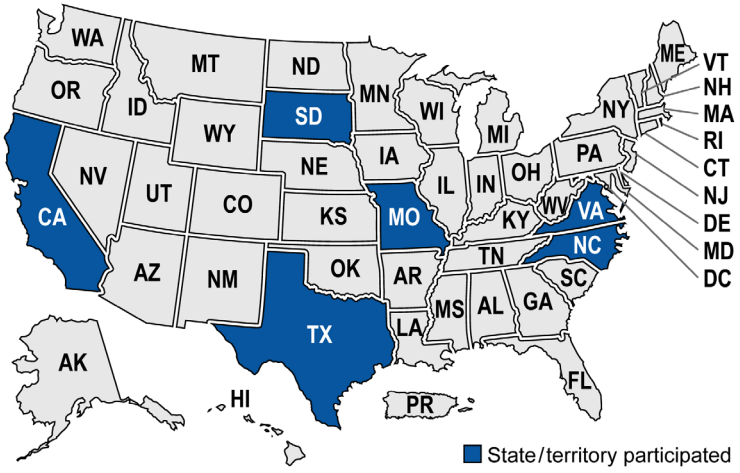
Regular, high-quality well-child visits are crucial for maintaining children's health. These routine visits enable providers to monitor growth and developmental milestones, support caregivers, and perform important screenings such as vision and hearing checks and behavioral and oral health assessments.

The American Academy of Pediatrics and Bright Futures recommends nine well-care visits by the age of 15 months.[1] When children receive the recommended number of visits, they are more likely to be up-to-date on immunizations and have developmental concerns recognized and treated early, and are less likely to have an emergency department visit during infancy.[2]

Medicaid and the Children's Health Insurance Program (CHIP) cover nearly 37 million children, providing access to well-child visits and other preventive health care services.[3] Despite the well-know importance of well-child visits, a median of only 58 percent of children covered by Medicaid and CHIP received six or more well-child visits in their first 15 months of life.[4]

To support states in achieving the recommended number of infant well-child visits for their beneficiaries, the Centers for Medicare & Medicaid Services (CMS) convened the Improving Infant Well-Child Visits Affinity Group. From December 2021 to December 2023, six states participated in the affinity group (Figure 1). CMS supported state teams in conducting quality improvement (QI) projects and facilitated peer-to-peer learning and sharing of promising practices across states. A principal objective of the affinity group was to help states develop data-driven, sustainable solutions for improving access to and quality of infant well-child visits in Medicaid and CHIP.

Figure 1. State Participation in the Improving Infant Well-Child Visits Affinity Group



[1] The full well-child visit periodicity schedule is available at https://www.aap.org/periodicityschedule.

[2] More information about the importance of improving well-child visits is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html.

[3] Data as of April 2024, available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/april-2024-medicaid-chip-enrollment-trend-snapshot.pdf.

[4] As reported by 48 states on the Well-Child Visit in the First 30 Months of Life (W30-CH) measure for FFY 2022 Child Core Set reporting. Measure Performance Tables on the Child Core Set Measures are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html#AnnualReporting.

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Using a Data-Driven Approach to Develop Well-Child Visit QI Interventions

CMS provided technical assistance (TA) to help state teams use data to identify disparities and improvement opportunities, select measures to monitor their QI projects, and review data to understand the impact of their QI interventions.[5]

All states participating in the affinity group reported the percentage of infants receiving six or more well-child visits in the first 15 months of life as part of the 2020 Child Core Set (Box 1). This measure provided a starting place for state teams to understand their performance in delivering infant well-child care to Medicaid and CHIP beneficiaries.

Box 1. Well-Child Measures in the Child Core Set

The 2020 Child Core Set included the Well-Child Visit in the First 15 Months of Life (W15-CH) measure, which assesses the percentage of infants with six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life. Beginning with the 2021 Child Core Set, the measure steward, the National Committee for Quality Assurance (NCQA), replaced the W15-CH measure with the Well-Child Visits in the First 30 Months of Life measure (W30-CH).

The W30-CH measure assesses the percentage of children who had well-child visits with a PCP during the first 30 months of life. The W30-CH measure includes two rates: the percentage of Medicaid and CHIP beneficiaries with six or more visits in the first 15 months of life (formerly the W15-CH measure) and the percentage with at least two visits between 15 and 30 months. The Child Core Set also includes two additional measures of well-child visits for older children and adolescents.

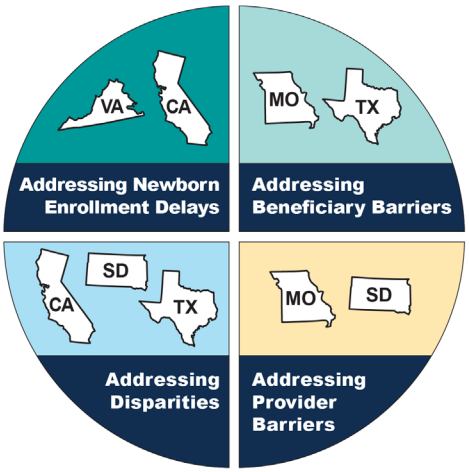
Many state teams partnered with other organizations, such as state and local health agencies and managed care plans (MCPs), to collect additional data. State teams used QI tools, such as process flow maps and beneficiary outreach, to understand barriers and opportunities for improving infant well-child care in their state.[6]

North Carolina partnered with their MCPs to align their QI work with the state's newly implemented managed care program. Using the tools and resources provided through the affinity group, the state team launched a learning collaborative with five MCPs and provided TA on QI best practices, including developing aim statements, measurement strategies, and small tests of change related to increasing infant well-child visit rates.

Testing Interventions to Improve Infant Well-Child Visits

Once state teams understood the opportunities for improvement demonstrated through their data, they worked with their partners and CMS to identify QI interventions, also known as change ideas. These change ideas focused on addressing newborn enrollment delays, beneficiary barriers, provider barriers, and disparities (Figure 2).

Figure 2. Focus Areas for State Team QI Projects



Addressing Newborn Enrollment Delays

California's state team hypothesized that infant well-child visits were missed due to delays in newborn enrollment. After developing a process flow map and reviewing infant well-child care data, the state team found that infant visits were sometimes billed under the

[5] A measurement strategy that provides examples of measures for monitoring well-child visit projects is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html.

[6] A process flow map, or flow chart, is a visual display of the steps in a process. It can help with designing and testing new processes and support teams in identifying problems, gaps, and inefficiencies. More information on using process flow maps for QI is available at https://www.ihi.org/resources/Pages/Tools/Flowchart.aspx.

mother's Medicaid identification number (ID). This meant the state's overall well-child visit rate did not reflect the number of completed visits. One MCP conducted member outreach and found that most members (86 percent) attended an infant well-child visit, but only half of these visits appeared in claims data. Additionally, the state team identified a lag in the data, where an infant's Medicaid ID did not appear on an MCP's list until they were four months old. This resulted in delays in outreach to families who may have benefited from scheduling assistance or reminders.

The state team then tested ways to improve timely newborn Medicaid enrollment. Two MCPs collaborated to develop a newborn checklist with the goal of helping new parents navigate the Medicaid enrollment process. The MCPs tested two approaches: (1) distributing the checklist[7] alone and (2) distributing the checklist and providing follow-up member outreach that included questions about the member's potential transportation needs. After testing, the MCPs found a larger increase in visit attendance rates among members who received both the checklist and outreach than those who only received the checklist. Clinical staff also noted that the checklist was helpful and voiced appreciation for the extra support from the MCPs.

Virginia partnered with several MCPs to conduct phone outreach to members to understand their challenges in making and keeping well-child visit appointments. The state team learned that caregivers were unaware they needed to apply for a permanent Medicaid ID for their infant. This misunderstanding led to coverage delays and contributed to missed well-child visits and other disruptions in care. By the end of the affinity group, the state implemented a process improvement whereby newborns were automatically enrolled in Medicaid.[8]

Addressing Beneficiary Barriers

Several state teams sought to increase visit completion by helping families overcome barriers to scheduling and attending infant well-child visits. They tested various strategies, including beneficiary outreach and scheduling infant well-child visits before hospital discharge.

Several of **Texas's** 10 participating MCPs tested beneficiary outreach and education interventions. One MCP conducted outreach phone calls to the families of infants, reaching over 70 percent. During the call, a case manager discussed newborn feeding cues, encouraged breastfeeding, provided reminders on infant well-child visits, and directed the family to additional support. Another MCP partnered with a pediatric practice to conduct outreach calls after the 12-month well-child visit. These calls focused on sharing the importance of the 15-month well-child visit and providing scheduling support if needed. Based on testing success, the MCP plans to spread its outreach call intervention to 15 other pediatric practices.

Missouri partnered with one MCP and a local health system to enroll new parents and their infants in a patient portal before hospital discharge. After three rounds of testing, the state team found high attendance rates for infant well-child visits among families that activated their patient portal accounts before hospital discharge. At the end of the affintiy group, the state team was discussing ways of expanding the intervention to other health systems.

Addressing Provider Barriers

Several state teams created education tools for providers and support staff to address challenges related to scheduling and billing for infant well-care visits.

South Dakota aimed to increase services provided during a single visit to reduce the total number of visits families make to a physician's office. In a largely rural state like South Dakota, transportation challenges and long travel times are barriers to care. The team issued guidance to providers and office staff to schedule all children in this age range for a well-child visit instead of nurse-only immunization visits. The state learned from provider outreach that providers needed technical assistance and billing guidance when an acute care (sick)

[7] The Newborn Checklist is publicly available at https://www.childrennow.org/wp-content/uploads/2023/12/newborn-checklist-talking-points-final-6.13.2022-affinity.pdf.

[8] More information on Virginia's enrollment policy is available at https://vamedicaid.dmas.virginia.gov/vamed/download-pdf-bulletin/20036.

visit and a well-child checkup were completed on the same day for the same child. The state team developed guidance on billing for these combined visits and disseminated it through a provider listserv.

Missouri developed a desktop scheduling reference tool for provider office staff. The tool provided background on vaccination schedules and recommended timeframes for well-child visits. It also included information on billing for well-child visits to ensure an accurate well-child visit measure rate and a smooth reimbursement process. Although the state team continued to test this strategy after the close of the affinity group, early feedback from providers indicated that the desktop tool was widely used and seen as a valuable resource.

Addressing Disparities

Several state teams sought to reduce disparities in infant well-child visit attendance by working with local partners, creating tailored educational materials, and focusing outreach efforts.

California worked with partners to address disparities in well-child visit rates among Black/African American infants. One MCP partnered with Black Infant Health, a health equity program that offers individual and group support to pregnant and postpartum Black parents in several California counties. The MCP worked with the program to integrate well-child visit education by providing presentations, transportation support information, and incentives. Members participating in the project said that the incentives helped them maintain engagement and connection and they found the transportation information helpful.

South Dakota focused on addressing disparities in well-child visit rates among infants who are American Indian/Alaska Native. The state team developed tailored, culturally relevant materials encouraging well-child visits and shared them via social media platforms. They shared the materials with state communications staff for use in other initiatives. Additionally, the state team distributed rack cards (brochures) to Indian Health Services clinics. The rack cards provided information on the importance of well-child visits and were shared in clinic waiting rooms. Though testing the rack cards was still underway at the end of the affinity group, the state team began expanding the cards to all pediatrician offices.

Texas sought to address both racial and geographic disparities. After identifying that certain rural zip codes had lower infant well-child visits, one MCP began outreach to rural members on behalf of high-volume pediatric clinics. Care coordinators reviewed the importance of infant well-child visits and immunizations during these calls. The MCP also provided text message reminders for upcoming visits. Another MCP focused outreach to Black and Latino members from three provider practices. The MCP implemented a tiered approach that included outreach calls followed by mailed letters to members not reached by phone. The state team was still assessing the impact of these strategies when the Affinity Group concluded.

For More Information

More information about the Improving Infant Well-Child Visits Learning Collaborative is available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Technical assistance resources are available to help states develop their own well-child QI projects, including background materials, a driver diagram and change idea table, and a measurement strategy.

More information about other Medicaid and CHIP QI initiatives is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html.

To obtain technical assistance, please email MedicaidCHIPQI@cms.hhs.gov.

About the CMS Medicaid and CHIP Quality Improvement (QI) Program

The CMS Medicaid and CHIP QI program provides state Medicaid and CHIP programs and their QI partners with the information, tools, and expert support they need to improve access, care, and outcomes for Medicaid and CHIP beneficiaries. Technical assistance is available to help states build QI knowledge and skills; develop QI projects; and implement, spread, and scale up QI initiatives. Participation is voluntary and involves collaboration between Medicaid and CHIP program leaders and other partners, including MCPs and public health agencies.