QI 201
Learning Session #8
Sharing Lessons Learned

April 25, 2014
2:30 – 3:30 pm (ET)
Agenda

• Welcome and Introductions
• QI 201 to Date
• Sharing Lessons Learned
• Next Steps
QI Team Introductions

Medical/CHIP Health Care Quality
Strengthening Maternal and Infant Health
Today’s Focus

• QI 201 Recap
• Sharing Lessons Learned
  • Iowa
  • Pennsylvania
  • Florida
  • Georgia
QI 201 Goals

• Build capacity to conduct quality improvement projects
• Accelerate improvement in Maternity Core Measures
• Facilitate shared learning among Medicaid teams around improving the health of maternal and perinatal populations
# QI 201 Learning Sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>Topics Covered</th>
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</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>August 2013</td>
<td>Overview of Learning Series</td>
</tr>
<tr>
<td>Session 1</td>
<td>September 2013</td>
<td>Team Introductions and Overview of the Model for Improvement</td>
</tr>
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<td>Session 2</td>
<td>October 2013</td>
<td>Engaging Stakeholders and Aim Statements</td>
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<td>Session 3</td>
<td>November 2013</td>
<td>Driver Diagrams</td>
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<td>Session 4</td>
<td>December 2013</td>
<td>Designing Tests of Change</td>
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<td>Session 5</td>
<td>January 2014</td>
<td>Measuring Improvement</td>
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<td>Session 6</td>
<td>February 2014</td>
<td>Using Data</td>
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<td>Session 7</td>
<td>March 2014</td>
<td>Building Improvement Capacity in the Field</td>
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<td>Session 8</td>
<td>April 2014</td>
<td>Recap and Team Sharing</td>
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<td>Session 9</td>
<td>May 2014</td>
<td>Wrap-up and Team Sharing</td>
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# QI 201 Team Projects

<table>
<thead>
<tr>
<th>Team</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Prenatal, Interconception, and/or Perinatal Care</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Decreasing Early Elective Deliveries</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Postpartum Care</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Tobacco Cessation for Pregnant Women</td>
</tr>
<tr>
<td>Georgia</td>
<td>Pediatric Medical Home (including Maternal Depression Screening)</td>
</tr>
</tbody>
</table>
Team Sharing
Iowa QI Project
Maternal Tobacco Cessation

Paul Bryan, Lori Jarmon, Rachel Johnson, Jason Kessler, MD, Sally Nadolsky, Koreen Rayl and Kelly Williams
Iowa Project Overview

**Aim:** By April 14, 2014, we want to improve Maternal Tobacco Cessation for Iowa Medicaid members to achieve the following results:
1. Reduce the percentage of maternal smoking during 3rd trimester from 22.2% to 19%.
2. Increase the number of provider referrals to Quitline by 50% for Medicaid members who are pregnant.
3. Increase provider confidence in the use of appropriate smoking cessation techniques for pregnant patients, including discussion of the risks and benefits of medications when appropriate, by 25% by April 2014 and by 50% by December 2014.

**Stakeholders and Partners**
Laura Eiklenborg, OPTUM
Michelle Gogerty, March of Dimes
Lynn Himmelreich, ARNP, Univ. of Iowa
Debra Kane, PHD, IDPH
Laura Malone, Iowa Hospital Association
Meg Nugent, IDPH
Jerilyn Oshel, Div. Tobacco Prevention
Di Petsche, IDPH
Betsy Richey, IDPH
Suzanne Rita, Magellan
Dawn Schissel, MD, IA Academy Family Physicians
Stephanie Trusty, IDPH
Debra Waldron, MD, UIHC
Denise Wheeler, IDPH

**What shaped our decision to implement a QI Project on your selected topic?**
- Maternal Tobacco use-Prevalence 25-30% (n=3161-3794)
- Reducing maternal tobacco use is a priority in the state of Iowa
- Tobacco use is associated with 11% of Medicaid spending (national)
- Improve birth outcomes (Ectopic pregnancy, fetal death, PTB, LBW, placenta abruption, etc.)
- Will increase quality of care, improve health outcomes, and/or reduce medical expense
Iowa Driver Diagram

Reduce % of maternal smoking during 3rd trimester from 22.2% to 19%

Increase the # of provider referrals to Quitline by 50% for Medicaid members who are pregnant

Increase provider confidence in use of appropriate smoking cessation techniques for pregnant patients by 25% by April 2014 and by 50% by December 2014

Outreach and educate OBGYN and health care providers

Educate OBGYN and health care providers on Iowa Quitline

Engage OBGYN and health care providers

Provide educational materials on alternative to smoking to providers and health care providers.
- Letter from IA ACOG chair to providers
- Two Informational Letters (ILs) to providers about IDPH on-line Smoking Cessation training and codes used for smoking cessation counseling
- Several newsletter articles to providers such as PERINATAL Letter, Iowa Academy of Family Physicians, OB nurses, Chronic Disease Connection, CHPN

Provide Quitline materials to providers.
- Two ILs to providers about QIP including how to refer Medicaid members to Quitline w/ links to forms
- Develop Quitline flyers to distribute to providers

Determine provider level of smoking cessation confidence and provide educational materials on alternatives to smoking to providers.
- Conducted an online survey to assess provider confidence with tobacco cessation techniques
- Site visits will be conducted to assess best ways to assist providers with maternal smoking cessation techniques
## Iowa Measurement Plan

**Measurement Strategy:** Testing the impact of provider education and outreach

### Outcome Measures
- Percentage of maternal smoking during 3rd trimester reduced
- Percentage of Quitline referrals increased
- Percentage of provider confidence with smoking cessation increased

### Process Measures
- Percentage of maternal smoking cessation reported at medical visit
- Percentage of Quitline referrals reported by vendor
- Percentage of provider confidence self-reported in online survey

### Balancing Measures
- Birth certificate data
- Provider experience data (online survey)
- Improved Quitline reports

## Data Collection Strategy:

### Data being used:
- Birth certificates
- Online surveys
- Site visits
- Reports from Quitline

### Partners in data collection and analysis:
- Quitline
- IDPH
- Iowa QI 201 team

### Frequency of data collection:
- Birth certificates (annually)
- Quitline (monthly)
- Surveys (biannually)
If pregnant patients report that they smoke, how often does your practice discuss smoking cessation methods and strategies with the patient?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3.2%</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>23.4%</td>
<td>22</td>
</tr>
<tr>
<td>Usually</td>
<td>29.8%</td>
<td>28</td>
</tr>
<tr>
<td>Always</td>
<td>43.6%</td>
<td>41</td>
</tr>
</tbody>
</table>

Data from: IME Provider Survey, 2014

Opportunity!
Iowa Team Reflection

**Learning:** How will you use the information from your early tests of change to modify your QI approach?

*May need to increase education and outreach opportunities to encourage providers to refer pregnant patients to Quitline*

What surprised you about the work you have done so far on your project?

*Providers reported they were too busy to participate in a pilot*

What assumptions, if any, did you have at the beginning that have been challenged?

*We thought that practices would be enthusiastic about the opportunity to work with us on the Tobacco Cessation project.*

What advice would you have for another QI Team beginning a project like yours?

*Have a back-up plan in place if the initial plan doesn’t work. We spent a lot of time organizing a pilot to recruit providers to help with baseline data collection and when that didn’t work we had to quickly organize an alternative way to get the baseline data.*

**Scaling:** How will you scale and spread your QI project going forward?

*Recruiting and involving more clinics.*
Questions and Discussion
Improving Maternity Care in Pennsylvania’s Medical Assistance Disparate Populations

Michele Robison
Office of Medical Assistance Programs
Pennsylvania QI Project Overview

Aim: Pennsylvania’s goal is to improve maternity care in its disparate Medical Assistance population.

Approach: Pennsylvania implemented Pay-for-Performance Programs, Reporting Requirements, and an Electronic Data Element Extraction Initiative to improve maternity care in disparate populations.

Stakeholders and Partners

<table>
<thead>
<tr>
<th>Stakeholders and Partners</th>
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<tbody>
<tr>
<td>Medicaid Managed Care Organizations</td>
</tr>
<tr>
<td>PA Department of Public Welfare, Office of Medical Assistance Programs</td>
</tr>
<tr>
<td>PA Department of Health</td>
</tr>
<tr>
<td>External Quality Review Organization (EQRO)</td>
</tr>
</tbody>
</table>

What shaped your decision to implement a QI Project on your selected topic?

- Medicaid beneficiaries have higher birth rates
- Medicaid beneficiaries have higher rates of non-compliance with pregnancy care
- Preventing one negative birth outcome can save millions of healthcare dollars
- Race/Ethnicity data has shown disparities exist between African American and White
Pennsylvania Driver Diagram

Improve Maternity Care in Medicaid Disparate Population

- Timeliness of Prenatal Care
- Frequency of Ongoing Prenatal Care: ≥ 81% Expected Visits
- Postpartum Care
- Percentage of Live Births Weighing Less than 2,500 Grams
- Perinatal Depression Screening

- MCO Pay-for-Performance
- Provider Pay-for-Performance
- BMCO Oversight – Quarterly Quality Reviews
- OB Needs Assessment Data from Adult Quality Measures Grant

- MCO Pay-for-Performance
- Provider Pay-for-Performance
- BMCO Oversight – Quarterly Quality Reviews
- OB Needs Assessment Data from Adult Quality Measures Grant

- OB Needs Assessment Data from Adult Quality Measures Grant
- DOH Vital Statistics Information
- PA Performance Measure
- CHIPRA Quality Measure

- OB Needs Assessment Data Form
- PA Performance Measure
- BMCO Oversight – Quarterly Quality Reviews

Medicaid/CHIP Health Care Quality
Strengthening Maternal and Infant Health
Pennsylvania Measurement Plan

**Measurement Strategy:**
- HEDIS® Reporting
- PA Performance Measures Reporting
- Data Element Extraction from OB Needs Assessment Form

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Process Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Live Births Weighing Less than 2,500 Grams</td>
<td>Timeliness of Prenatal Care</td>
</tr>
<tr>
<td></td>
<td>Frequency of Ongoing Prenatal Care: ≥ 81% Expected Visits</td>
</tr>
<tr>
<td></td>
<td>Postpartum Care</td>
</tr>
<tr>
<td></td>
<td>Perinatal Depression Screening</td>
</tr>
</tbody>
</table>

**Data Collection Strategy:**
- Encounter data submitted by the Managed Care Organizations
- Data extraction from the Provider’s EHRs
- Data validation by EQRO
Data from Pennsylvania

Prenatal Care in the First Trimester

**Measure Description:**
The percentage of women who received prenatal care during their first trimester of pregnancy.

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>2004 (Baseline)</th>
<th>2009 (P4P Year 5)</th>
<th>2010 (P4P Year 6)</th>
<th>2011 (P4P Year 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC Wtd Avg</td>
<td>82.3%</td>
<td>84.5%</td>
<td>85.9%</td>
<td>86.7%</td>
</tr>
<tr>
<td>50th Percentile BM</td>
<td>81.3%</td>
<td>85.9%</td>
<td>86.0%</td>
<td>86.1%</td>
</tr>
<tr>
<td>75th Percentile BM</td>
<td>86.4%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.4%</td>
</tr>
<tr>
<td>90th Percentile BM</td>
<td>89.5%</td>
<td>92.7%</td>
<td>93.2%</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

**HealthChoices Plan-Specific Rates by Calendar Year**

1. Arrows indicate a statistically significant change from the previous year.
Data from Pennsylvania (cont’d)

Frequency of Ongoing Prenatal Care: ≥81% of the Expected Number of Prenatal Care Visits

**Measure Description:**
The percentage of pregnant women who received 81% or more of the expected number of prenatal care visits.

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>2004 (Baseline)</th>
<th>2009 (P4P Year 5)</th>
<th>2010 (P4P Year 6)</th>
<th>2011 (P4P Year 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC Wtd Avg</td>
<td>59.3%</td>
<td>72.8%</td>
<td>72.6%</td>
<td>72.2%</td>
</tr>
<tr>
<td>50th Percentile BM</td>
<td>57.5%</td>
<td>64.2%</td>
<td>64.4%</td>
<td>64.7%</td>
</tr>
<tr>
<td>75th Percentile BM</td>
<td>67.6%</td>
<td>73.7%</td>
<td>74.9%</td>
<td>73.0%</td>
</tr>
<tr>
<td>90th Percentile BM</td>
<td>80.0%</td>
<td>82.2%</td>
<td>81.8%</td>
<td>82.6%</td>
</tr>
</tbody>
</table>

1. Arrows indicate a statistically significant change from the previous year.
Data from Pennsylvania (cont’d)

Analysis of Racial Disparities: Prenatal Care

- For prenatal care rates, all HealthChoices Zones show disparities between African Americans and Whites for CY 2011\(^1\).

<table>
<thead>
<tr>
<th>HealthChoices Zone</th>
<th>Prenatal Care in the First Trimester</th>
<th>Frequency of Ongoing Prenatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>African American</td>
<td>White</td>
</tr>
<tr>
<td>Southeast</td>
<td>78.9%</td>
<td>84.2%</td>
</tr>
<tr>
<td>Southwest</td>
<td>89.5%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Lehigh/Capital</td>
<td>87.6%</td>
<td>94.5%</td>
</tr>
<tr>
<td><strong>All HealthChoices</strong></td>
<td><strong>81.5%</strong></td>
<td><strong>90.4%</strong></td>
</tr>
</tbody>
</table>

\(^1\) Prenatal care measures are: Prenatal Care in the First Trimester and Frequency of Ongoing Prenatal Care: \(\geq 81\%\) of the Expected Number of Prenatal Care Visits.
Pennsylvania Next Steps

**Learning:**
- PA’s weighted average for Prenatal Care weighted average is above the 50\(^{th}\) percentile
- Prenatal Care rates shows disparities exist between African Americans and Whites
- Frequency of Ongoing Prenatal Care weighted average is above the 50\(^{th}\) percentile
- Data element extraction has been challenging

**Scaling:**
- Quarterly Quality Review Meetings with the MCOs
- Continue MCO and Provider Pay-for-Performance Initiatives
- Plans not reaching the 50\(^{th}\) percentile benchmark will be penalized
- Continue to work with MCOs and EHR vendors to increase availability of data element extraction from EHRs
Questions and Discussion
Florida QI Project

Sustaining and Spreading the Pediatric PCMH Model

Contributors:
Florida Agency for Health Care Administration
Health Management Associates
University of Florida
University of South Florida
American Academy of Pediatrics
Ruth Gubernick Consulting
Florida Project Overview

**Aims:** To provide assistance to 35 practices in areas where they are having difficulty making or sustaining improvements.

To develop a plan on how to spread the medical home model to Florida pediatric practices who serve Medicaid/CHIP enrollees but did not participate in the CHIPRA Quality Demonstration Grant.

**Stakeholders and Partners**
- Florida Chapter of the AAP
- The Family Network on Disabilities
- Agency for Health Care Administration
- Department of Health
- Florida HATS
- Florida Healthy Kids Corporation
- Health Management Associates
- Florida Blue
- U of Florida
- U of South Florida

The decision to implement a PCMH project was influenced by
- A pilot project in Jacksonville that was administered in part by the Department of Health
- A state medical home report that was submitted to the legislature
- Promotion of the medical home by Florida Blue
- Evidence that there may be cost savings under the medical home model
- Ability to partner with the AAP who have expertise in facilitating medical home transformation
Florida Measurement Plan

**Measurement Strategy:** For the first aim we have 26 practice-level measures that are tracked and reviewed by practice facilitators.

Practice level measures include items such as:

- Percentage with an identified PCP
- Percentage whose identified PCP provided the most recent health supervision visit
- Percentage of comprehensive care plans offered and reviewed by families
- Percentage of visits where family concerns are elicited
- Percentage of follow up visits scheduled or recommended

Additionally, the practices are assessed on the non-hybrid core CHIPRA pediatric measures, CAHPS PCMH, and several staff and practice leadership outcomes.

**Data Collection Strategy:**

- Practice teams report the 26 measures monthly
- Additional data is assessed annually
Reported “surprises”
- We took things for granted that we were doing the right thing for the patient but our parent partners had a different perspective – we learned to respect and accept that.
- The amount of improvements achieved by asking our staff for ideas.
- Referral tracking is really helping us with follow-up.

Reported barriers
- Implementing a new EHR.
- Limitations of our EHR.
- Staff changes/turnover
- Getting parents to activate the patient portal..
- Consistent use of tracking tools.

Something important learned
- The value of teamwork!
- Daily huddles help us prepare for our patients and our day.
- Two-way communication is essential – everyone’s input must be elicited and encouraged.
- There is a need for continual for learning from small changes
- We get great feedback/input from our parents/families.
Added QI Wisdom…

• How to better help practices prioritize where they want/need to put their time and efforts for testing change

• How to encourage practices to use their data (i.e., baseline MHI results)

• How to create opportunities for practice teams to meet together (in between learning sessions) to share resources and experiences
Florida Spread Plan

We know practices can transform to become PCMHs, so how do move that to a statewide program?

- Initially we thought the spread portion of our QI project would occur through convening stakeholders, but this has proven to be difficult through our various efforts.
- We need to identify one organization willing to take on the sustainability and spread of PCMHs in Florida. The project has also recently named new chairpersons for our leadership group.
- We also struggled with determining the message and getting the attention of the Medicaid/CHIP stakeholders. Language in the 1115 Managed Care waiver is a step in the right direction!
- Operationalizing the PCMH is hard, especially when there is resistance to using national recognition programs (i.e. CHIP plans).
- We need to keep working on identifying what data is needed to motivate key stakeholders, providers, and other organizations to take on the medical home model. We are still processing our data so it may be premature to identify what data is needed.
- Ultimately, we need internal and external buy in and we seek a permanent leader for the pediatric medical home project that will be engaged in advocacy and spread.
Questions and Discussion
Georgia Reproductive Life Planning Pilot
Quality Improvement Project

- Jacqueline Collins, RN, CPHQ, Sr. Director, Quality Improvement, WellCare of Georgia, Inc.
- Lisa Maleski, MPH, Manager II, Amerigroup RealSolutions in Healthcare, Georgia
- Tracy D. Smith, Director of Provider Relations, Peach State Health Plan
- Cheryl C. Grant, Accreditation Specialist, Peach State Health Plan
- Dr. Janice Carson, Deputy Director of Performance, Quality and Outcomes, Georgia Department of Community Health
Georgia Reproductive Life Plan (RLP) Pilot

**Aim:** By April 2014, achieve a five percentage point increase over baseline in the number of pregnant women (within pilot practices) who have documentation in their medical chart of a reproductive life plan or a discussion about births and birth spacing.

**Approach:** Select and engage two high volume OB practices per CMO as pilot sites. Conduct face-to-face visits with each practice to explain the project and encourage reproductive life planning with their patients during antenatal visits.

### Stakeholders and Partners

<table>
<thead>
<tr>
<th>Department of Community Health (DCH)</th>
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</thead>
<tbody>
<tr>
<td>NICHQ (the National Initiative for Children’s Health Quality)</td>
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<tr>
<td>Amerigroup RealSolutions in Healthcare, Georgia</td>
</tr>
<tr>
<td>Peach State Health Plan</td>
</tr>
<tr>
<td>WellCare of Georgia, Inc.</td>
</tr>
</tbody>
</table>

**What shaped your decision to implement a QI pilot on your selected topic?**

- Georgia’s participation in the CoIIIN
- Georgia’s 1115 Demonstration
- Outcomes associated with the Demonstration
Global Goal:
Increase awareness and use of reproductive life planning (RLP) tools to prevent unplanned pregnancies and improve birth outcomes.

Smart Aim:
By April 2014, increase RLP discussions by 5 percentage points above baseline and document in the medical records of pregnant women within pilot practices.

Primary Drivers
- Member engagement
  - Educate providers to engage pregnant members in reproductive life planning discussions
  - Educate members about impact of birth spacing on poor birth outcomes.
  - Identify best time for member engagement by provider – during prenatal or postpartum period or both

- Provider engagement
  - Face to face engagement of providers by CMOs to spark interest in project
  - Utilize specialty society to facilitate provider engagement
  - Educate providers about RLP tools to ease their discomfort about the RLP discussion
  - Educate providers that contraceptive method discussion is not reproductive life planning

- RLP discussion
  - Provide providers with RLP tools to assist with discussions
  - Encourage use of ‘EWET’ RLP tool
  - Educate providers about alternative CDC RLP tool

- Documentation
  - Allow providers to use tools or simply document discussions in patient’s chart
  - Explain audit process to providers
  - Follow up with providers monthly and address any documentation concerns

Medicaid/CHIP Health Care Quality
Strengthening Maternal and Infant Health
Georgia RLP Measurement Plan

Measurement Strategy:
• Will test two hypotheses:
  • If face to face provider engagement improves frequency and documentation of reproductive life planning by pilot providers.
  • If pilot providers have a preference for the RLP tool used to document the discussions.
• Will measure the implementation and effects by conducting chart audits using a standardized audit tool

Data Collection Strategy:
• Each CMO’s Quality Improvement staff will collect and analyze chart audit data
• December 2013 will be used as a baseline measurement period, with monthly tracking going forward

Outcome Measure:
• Increased documentation of reproductive life planning by five percentage points over baseline.
Georgia RLP Data

- High volume practices that participated were primarily in the metro Atlanta area. Only one rural provider participated.
- From Baseline to Measurement Period 1, the combined CMO rate increased from 45% to 75% (an increase of 30 percentage points).
- Of the members with a documented RLP, 32% were unsure when to have the next child, 27% did not want more, and 14% wanted a child in 1 to 2 years.
- Method of pregnancy prevention used most frequently was condoms (62%) followed by birth control pills (18%).
Georgia RLP Data (cont’d)

When did the discussion occur?

<table>
<thead>
<tr>
<th>Timeline of Discussion</th>
<th>Count of Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>96</td>
</tr>
<tr>
<td>Postpartum</td>
<td>30</td>
</tr>
</tbody>
</table>

How Would You Describe Your Desire to Have a Child?

<table>
<thead>
<tr>
<th>Desire to Have a Child</th>
<th>Count of Desire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now or in the next year</td>
<td>12</td>
</tr>
<tr>
<td>In 1 to 2 yrs.</td>
<td>15</td>
</tr>
<tr>
<td>In 3 to 4 yrs.</td>
<td>12</td>
</tr>
<tr>
<td>In 5 or more years</td>
<td>6</td>
</tr>
<tr>
<td>Unsure about when</td>
<td>35</td>
</tr>
<tr>
<td><strong>Do not want more children</strong></td>
<td>29</td>
</tr>
</tbody>
</table>
Georgia RLP Data (cont’d)

What Method Do You Use to Prevent Pregnancy?

- Condoms: 61
- Birth Control Pills: 18
- Patch: 0
- Depo-Provera: 8
- Vaginal Ring: 2
- IUD: 3
- Tubal ligation: 3
- Diaphragm: 0
- ** None: 3

Methods of Prevention
Georgia RLP Pilot Next Steps

What we learned:
• Use of “Every Woman Every Time” form increased documentation and discussion
• Need to evaluate other methods of obtaining buy-in for change

What surprised us:
• Providers withdrew from pilot due to lack of evidence based information.
• Providers’ lack of documentation of Reproductive Life Planning process (completing but not documenting).
• Providers’ willingness to participate in the pilot but not commit to long term implementation.
• Condoms were the preferred method of contraception.
What surprised us (continued):

- In order to implement change, the environment must be supportive and the providers must be willing to change. The Georgia OB/GYN Society’s support was needed to implement the activity.

- There were technical constraints prior to implementation. Electronic Medical Record (EMR) systems used by the practices do not have Reproductive Life Planning modules or templates.

Assumptions that were challenged:

- EMRs are standardized to document Reproductive Life Planning discussions.

- Soliciting OB providers’ involvement in the pilot would be easy.
Georgia RLP Pilot Next Steps (cont’d)

Recommendations:

• Use pilot providers to champion the change for other providers.
• Link the change to other initiatives attractive to the providers, such as the immediate post partum insertion of Long Acting Reversible Contraceptives.
• Solicit ongoing support from the specialty society to promote and encourage the change.
• Use findings as means to market the change.

Scaling:

• More work is needed to expand the project beyond the current pilot sites.
• Need more provider buy-in and OB/GYN Society support in order to make change at the state and national levels.
Questions and Discussion
Coming Attractions

• **May:** Wrap Up, Scale Up, and Spread
Next Steps

• We are available for individual TA discussions about your team’s specific needs

• Please contact us through the TA Mailbox to schedule a TA discussion or for other support: MACqualityTA@cms.hhs.gov

Thank you for participating in today’s Learning Session.