QI 201
Learning Session #9
Sharing Lessons Learned

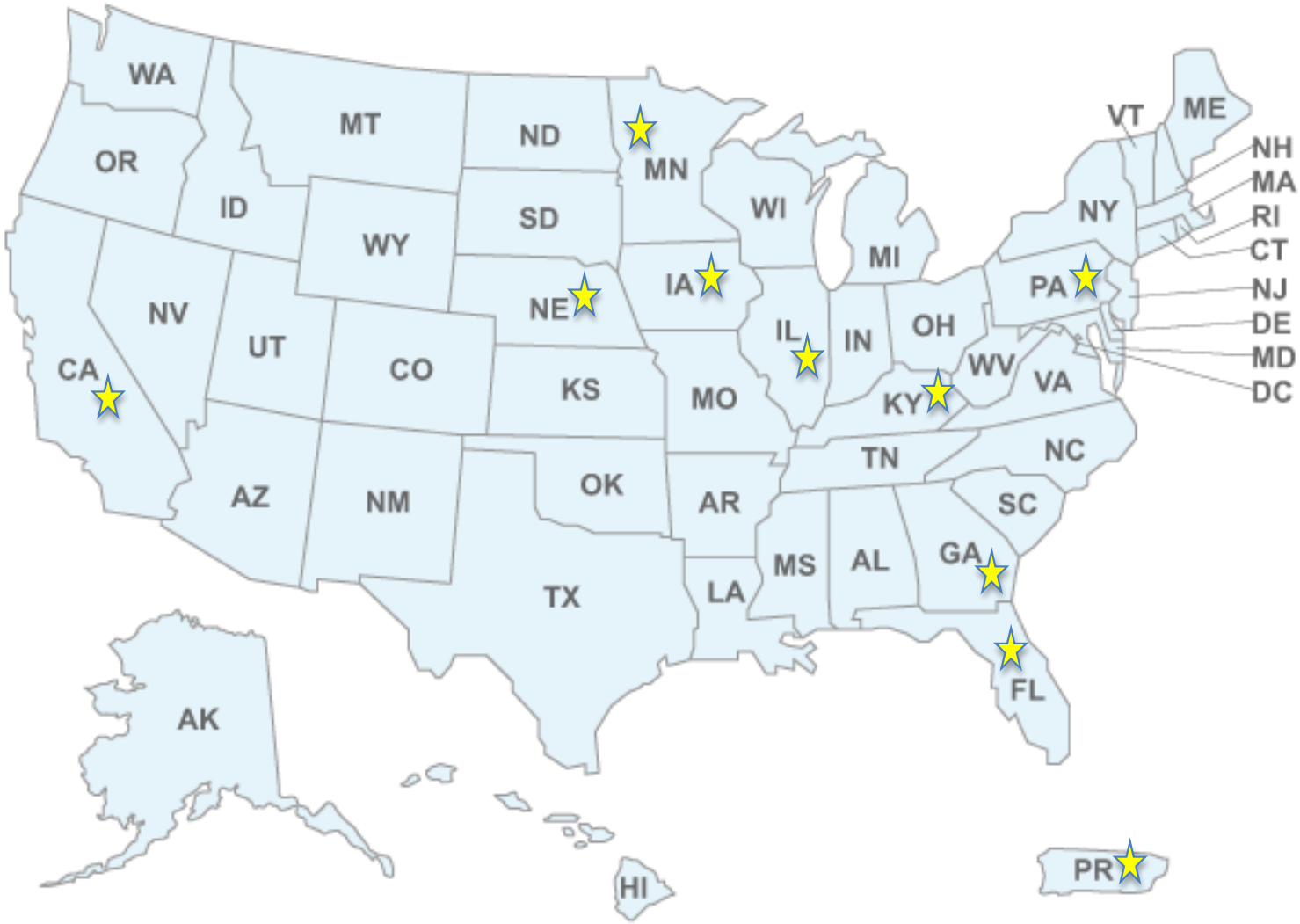
May 9, 2014

2:30 – 3:30 pm (ET)

Agenda

- Welcome and Introductions
- Scale-up and Spread
- Sharing Lessons Learned
- Next Steps

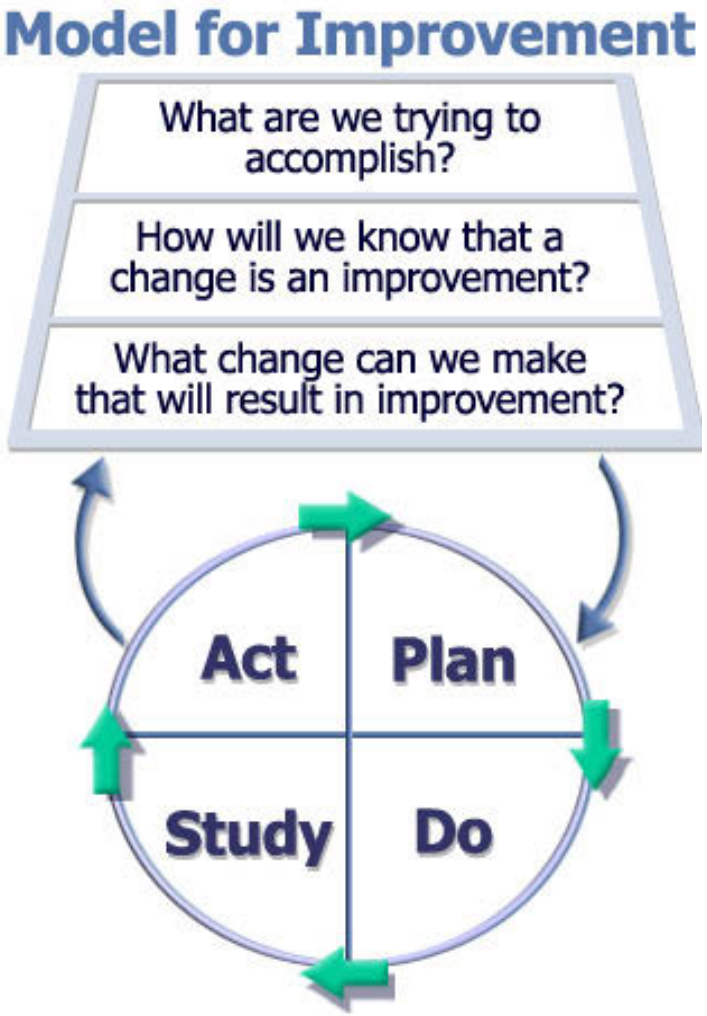
QI Team Introductions



Medicaid/CHIP Health Care Quality
Strengthening Maternal and Infant Health

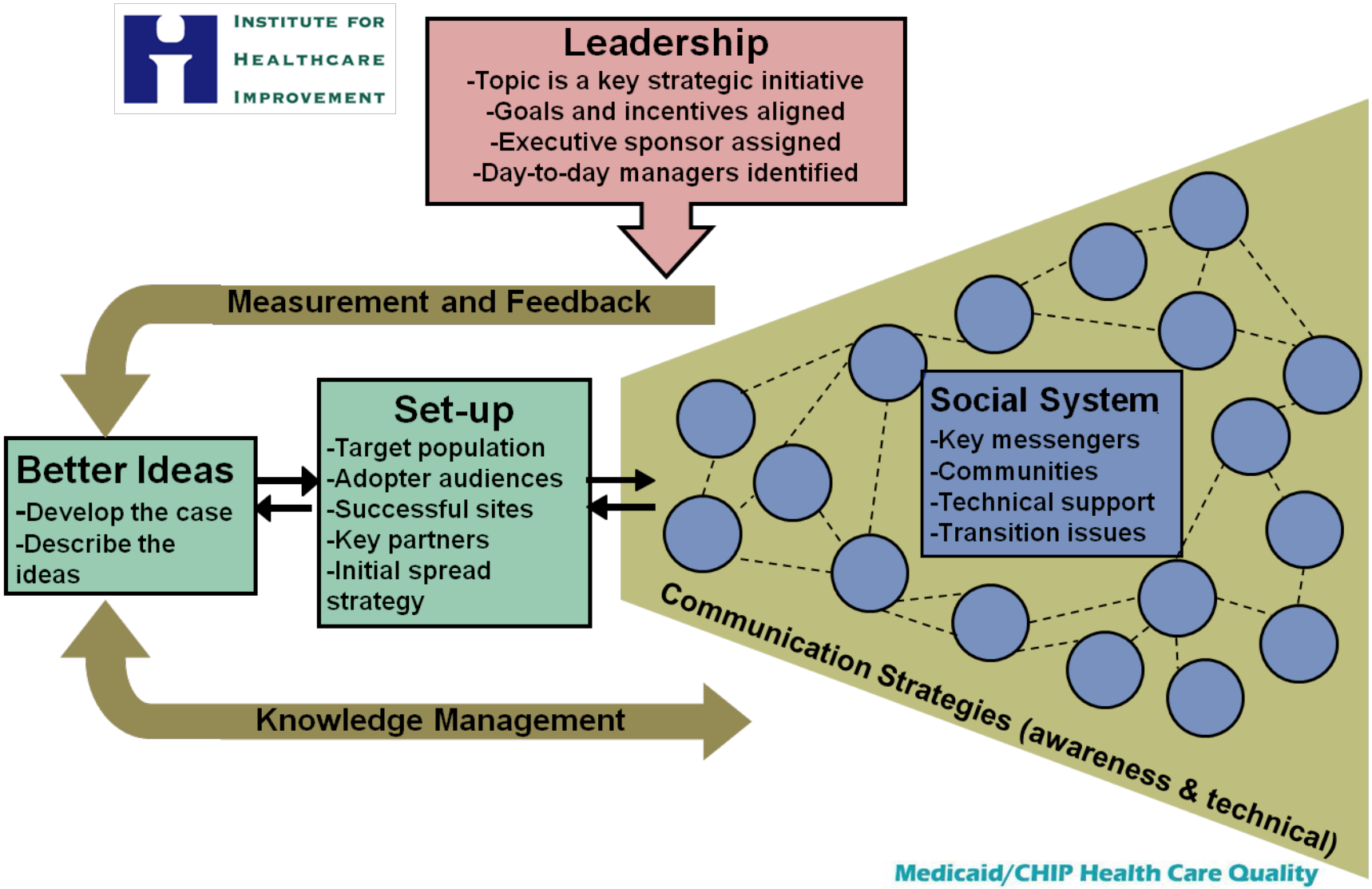
Today's Focus

- Scale-up and Spread
- Sharing Lessons Learned
  - Minnesota
  - Illinois
  - Puerto Rico



Scale-up and Spread

Framework for Spread



Strategies to Scale-up and Spread

- Identify systemic barriers to spread and potential solutions for overcoming them
- Consider the "Rule of 5" for scaling up further testing or implementation:
  - From 5 to 25 to 125 to 575 …

Considerations in Spreading Changes
• **New populations:** does your intervention need to be adapted?
• **Completeness and coverage:** did your intervention reach everyone in your target population?
• **New ideas:** have there been developments in research that could improve your intervention?
• **Oversight:** What kind of leadership structure is appropriate for a scaled-up project?

Team Sharing

Minnesota QI Project

Postpartum Depression Screening for Underserved Women

Susan Castellano, Maternal and Child Health Director, Minnesota Department of Heath – Collaborative Sponsor

Tessa Wetjen, MPA, Postpartum Depression Project Coordinator, Minnesota Department of Health, Maternal & Child Health Section – Collaborative Director

Kirsten Rewey, Sr. Evaluation Associate, ACET, Inc.

April 2014

Minnesota Project Overview

Aim: By November 30, 2014 we intend to ask mothers to be screened for depression/anxiety at least twice between their child's 2-week and 9-month well-child visit so that:

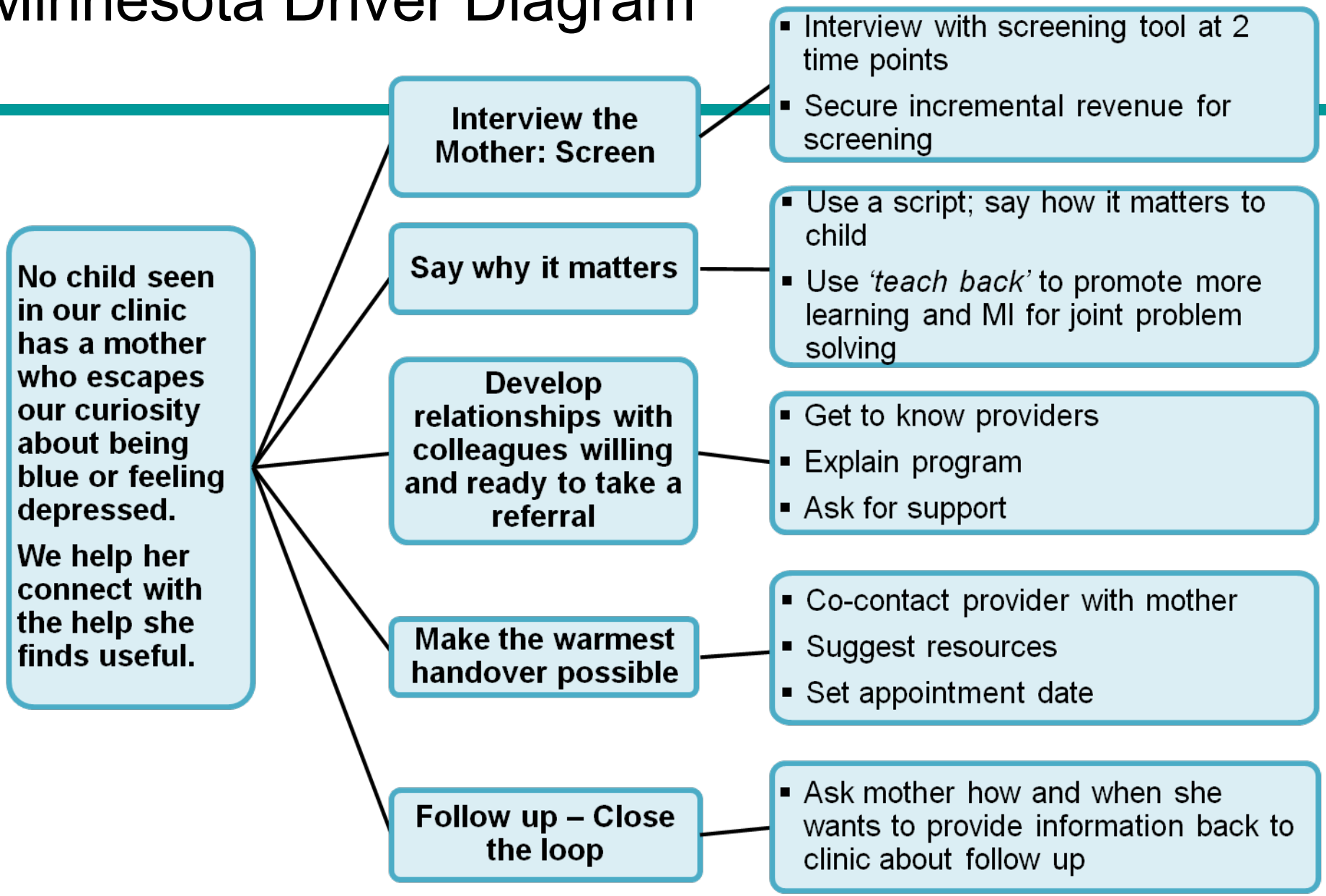
- 95% or more of mothers are screened,
- 100% with a positive screen are referred, and
- 95% or more get a follow-up from the clinic.

Stakeholders and Partners
6 Pediatric Clinics in our Pilot Learning Collaborative
Mental health providers in clinic communities
MN Department of Human Services • Healthcare Research and Quality Division • Children's Mental Health and Adult Mental Health Divisions
MN Department of Health • Family Home Visiting

We are doing this because:

- It will improve the health of mother and baby, and is therefore a high leverage change for Medicaid
- It builds on 3 previous developmental state-wide screening collaboratives
- It reaches mothers at a contact point with the healthcare system at a time they may advocate for their child but not themselves

Minnesota Driver Diagram



Minnesota Measurement Plan

Measurement Strategy:

- To test the best way to ensure that the depression screening tool is completed and scored prior to the provider coming into the room for the well child visit
- To test whether and how the intervention is impacting patients

Outcome Measures

- Number of screenings offered to moms
- Number of screenings completed
  - Positive screens (acute and non-acute)
  - Referrals made
  - Referrals completed

Process Measure

- Number of well child visits in time period

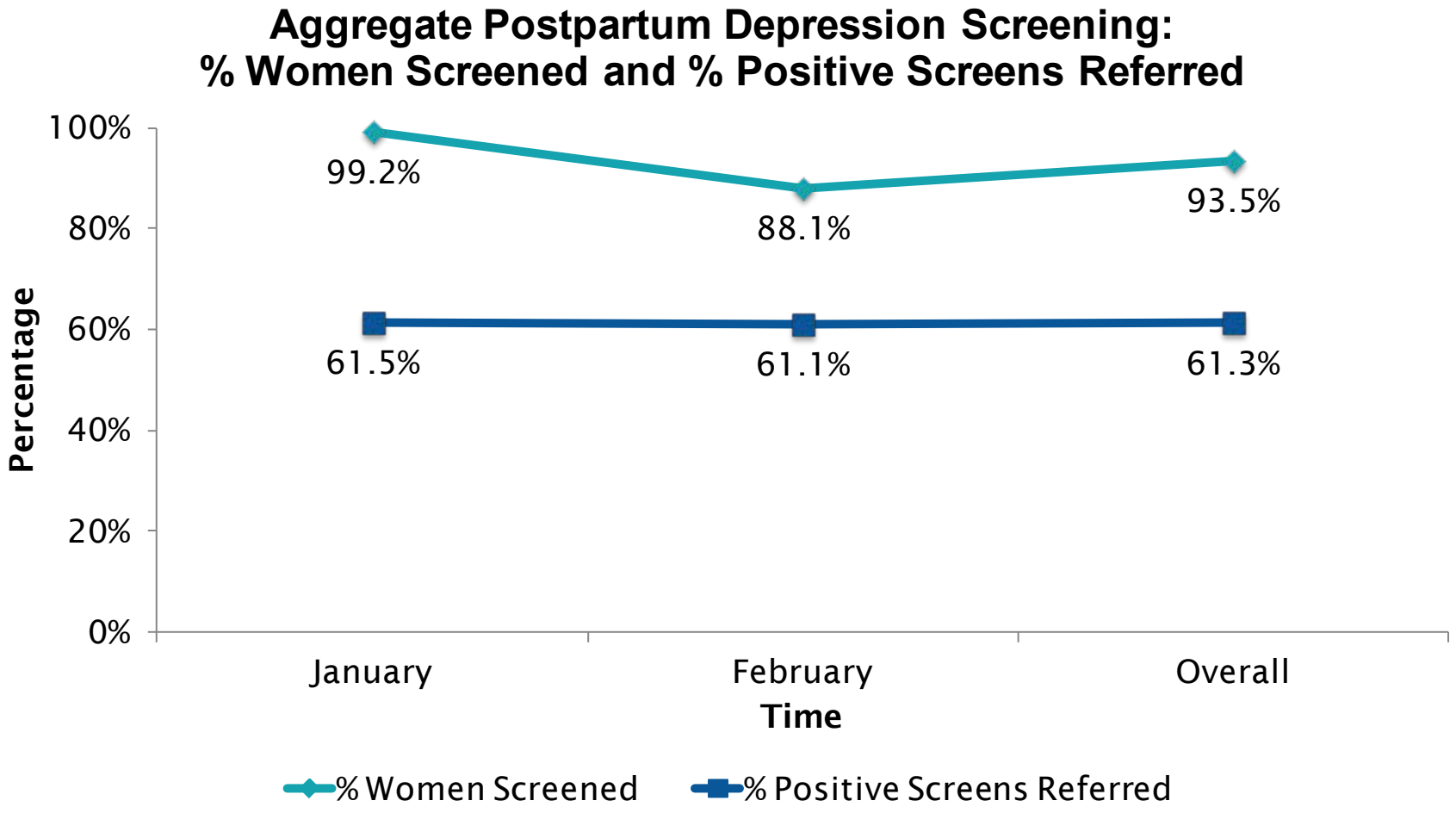
Balancing Measure

- % clinics reporting improved relationships with mental health providers

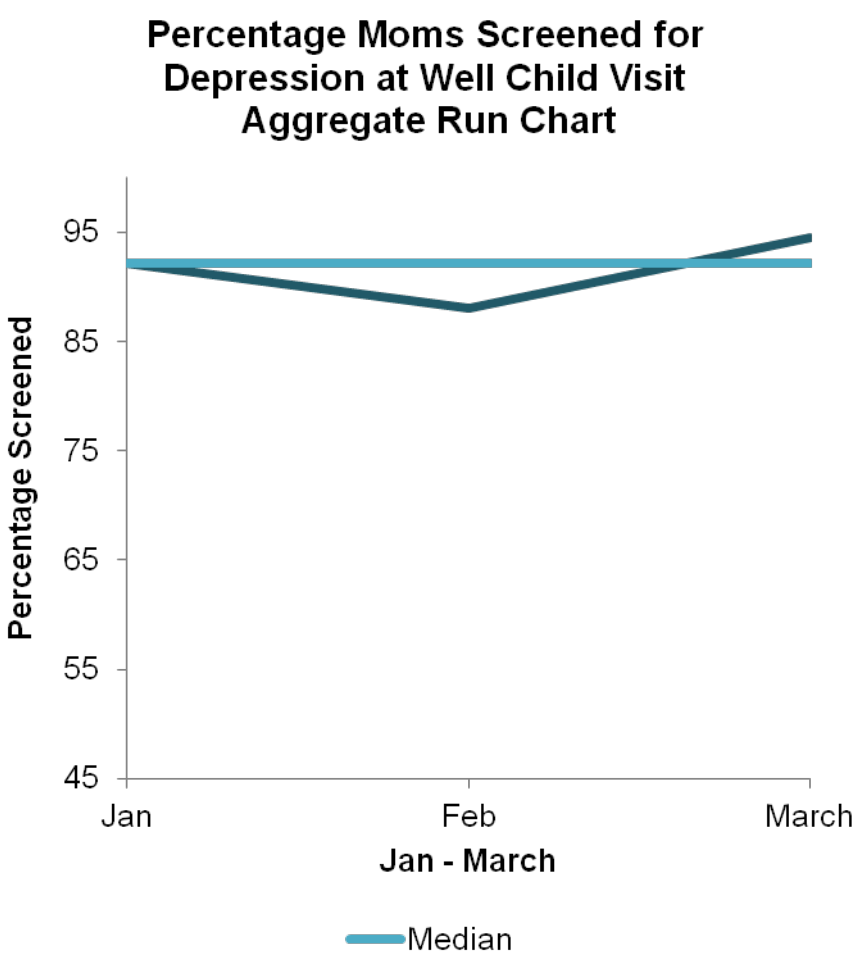
Data Collection Strategy:

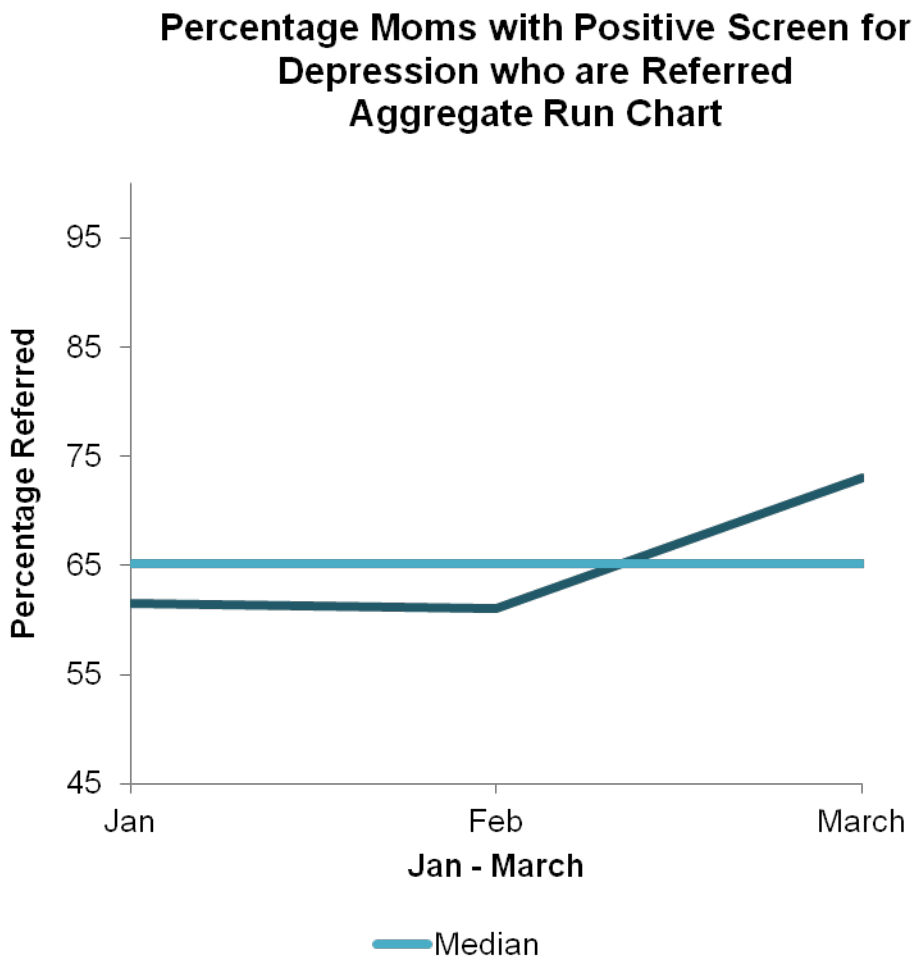
- Clinics report data monthly to external evaluator via SurveyMonkey
- Data is shared monthly with teams for learning and improvement

Minnesota Data



Minnesota Aggregate Data: Jan–Mar 2014





Minnesota Data (continued)

Metric/Graph	Numerator / Denominator	Data	%s
% Screen Offered at Visit	# Screens offered at WCCs	235	94.8%
	# WCCs	248	
% Screens Completed	# Moms agreeing to screens	232	93.5%
	# WCCs	248	
% Non-acute, Positive Screens	# Non-acute, positive screens	21	9.1%
	# Moms agreeing to screens	232	
% Acute, Positive Screens	# Acute, positive screens	10	4.3%
	# Moms agreeing to screens	232	
% Non-acute Referrals	# Non-acute positive screens w/referral	18	85.7%
	# Non-acute positive screens	21	
% Acute Referrals	# Acute, positive screens w/referral	6	60.0%

Minnesota Lessons Learned

- We learned that there is wide variation in the number of WCVs among the clinics in the time frame they selected.
- Screens from Time Period 2 seem to identify more mothers with depression/anxiety.
- Our positive rate is lower than the national average. Time Period 2 approximates the national average. We are surprised by the low number of screens, and we wonder if this relates to the differences in how they are thinking about age ranging.
- We assumed we would see more positive screens but it is still early.
- We would advise another state to think about defining when the screenings should occur so that the most mothers have the opportunity to be screened. Make sure clinics think through how they handle confidentiality issues around a mother's screen when she is not a patient in the clinic, and how they will document or track mother's results when the child is the patient.

Minnesota Spread Plan

After we learn what makes screening easy, how referrals are made without disrupting the clinic, and what influences whether mothers follow up, we will:

- Disseminate a simple change package and toolkit to all pediatric and family practice clinics in the state and work with AAP and AAFP to present at their meetings.
- Develop protocols for the state to get women screened, referred, and seen, building on current policy that pays for screening.
- Re-publicize this and work with mental health providers in the state to ensure mothers are seen.
- Host a statewide webinar featuring our teams and lessons learned.

Questions and Discussion

Illinois QI Project

Prenatal Care Quality Tool (PCQT)

Julie Doetsch
Alison Rhodes
Gwen Smith
Jeff Todd
Linda Wheal
Ann Borders, MD
Arvind Goyal, MD

Illinois Project Overview

Aim: By June 2014, we will select 4 pilot sites and initiate testing to learn about the use and implementation of our prenatal care quality tool to ultimately improve birth outcomes for pregnant women covered by Medicaid in Illinois.

Approach: Test the Prenatal Care Quality Tool among pilot sites to improve the consistency of prenatal care content and quality of care across providers.

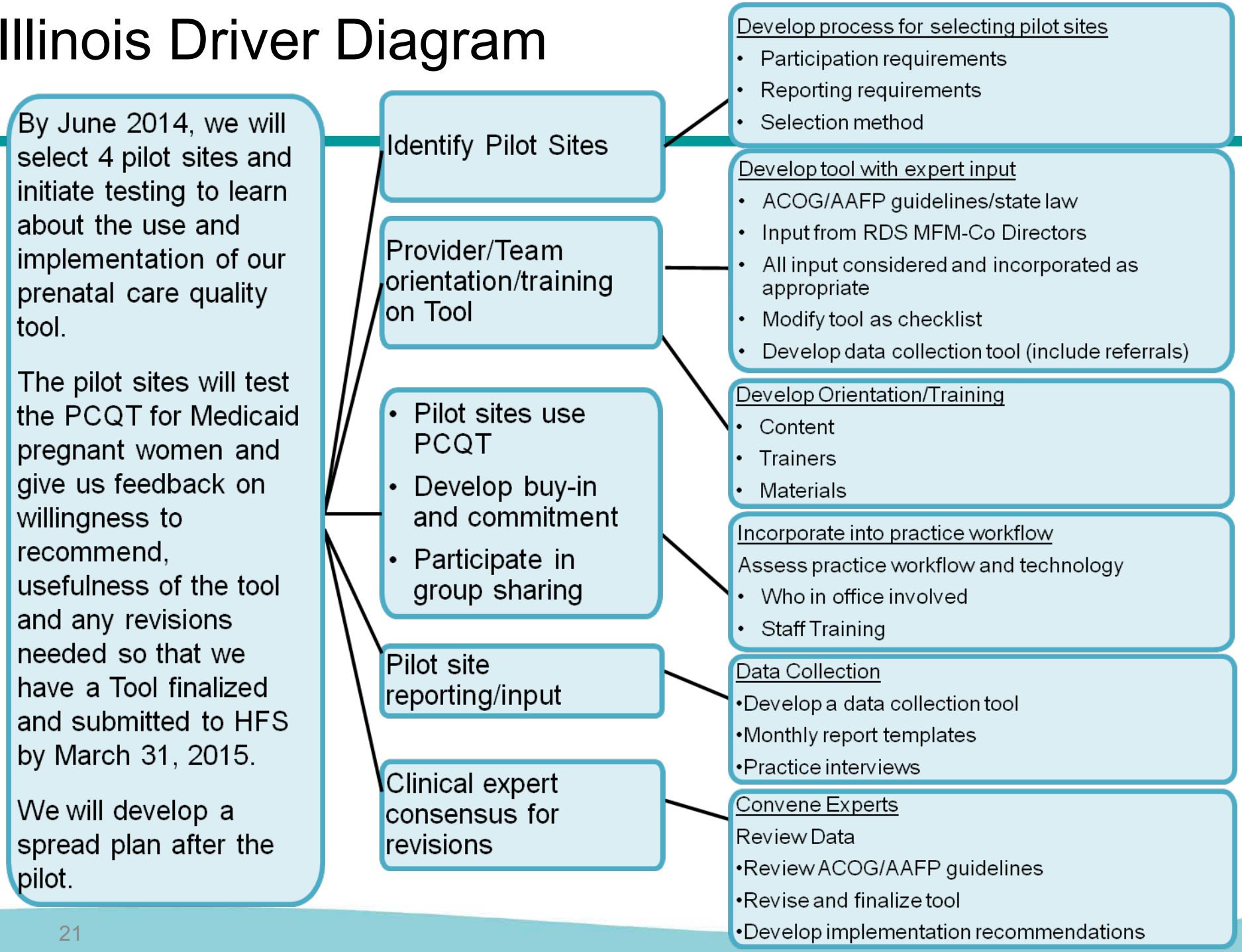
Stakeholders and Partners

Prenatal Care Clinics

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

- Based on previous medical record review, the majority of women's records had documentation of less than 80% of the recommended content of prenatal care in accordance with ACOG/AAFP recommendations and decreased documentation was correlated to adverse outcomes

Illinois Driver Diagram



Illinois Measurement Plan

Measurement Strategy: Testing the deployment of the PCQT

- 50% or more of women who receive care in a pilot site get the complete PCQT content or anticipatory guidance, at the right time in their prenatal journey
- 90% or more of the pilot providers find the tool 'very useful' and are willing to recommend it to a colleague

Outcome Measures	Process Measures	Balancing Measure(s)
• PCQT Content • Early Identification of High-Risk Condition • High-Risk Referrals • Postpartum Family Planning	• Providers Trained who Use the Tool • Tool Uptake	• PCQT Usefulness

Data Collection Strategy:

- PCQT checklist
- PCQT data collection tool
- Monthly reports
- Survey of providers who used the tool (at the end of the pilot period)
- HMA Data Analysis (monthly data collection)

Illinois QI Next Steps

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

- Provider input will be considered for making changes to the tool
- Will use the information to develop recommendations on best practices

Scaling: After learning from the 4 pilot sites and refining the tool, we will develop a spread plan for the State.

Questions and Discussion

Puerto Rico: Madres Saludables
(Healthy Mothers)

Maritza Espada, PRHIA
Yadira Berrios, PRHIA
Christopher E. Orozco, PRHIA
Benjamin Santiago, MD, Medical Director, Triple-S Salud
Josefina Díaz, MHR, Triple-S Salud
Luz Figueroa, MPA, Triple-S Salud

Puerto Rico Project Overview

Aim: By March 30, 2015, we want to increase the postpartum care (PPC) visits between 21 and 56 days and reduce no-show rates.

Approach: By working with the 4 medical practices in the Metro-North region with the highest volume of births, we will increase the PPC Visits within the 21-56 day period by 50% in the Metro North (MN) Region.

Stakeholders and Partners
Top four OB-GYN practitioners within the region
Members
Medical Plan
Local WIC Agency
Behavioral Plan Administrator (MBHO)
ASES

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

- Actual levels of PPC Visits HEDIS Rate Year 2013 showed 19.7% for PR and 18.3% for MN Region
- MN region represents the region with the most births and the second lowest rate of PPC visits
- This initiative is in accordance with PR State Quality Plan

Puerto Rico Driver Diagram

By March 30, 2015, we want to increase the postpartum care visits between 21-56 days and reduce no show rates.

Identify barriers to care from providers point of view:

- Provider compliance with clinical guidelines

- Share members survey results and PPC utilization data with physicians
- Educate providers on payment for 21-56 day visit
- Bring tools for proper scheduling and tracking of members
- Identify best practices

Identify barriers to care from members point of view:

- Education
- Physicians' appointment systems
- Social barriers (transportation, care of other children in family, etc.)
- C-section follow up care

- Conduct a focus group and survey
- Educate members about the importance of C-section follow up for incision (versus post partum care visit)
- Educate about transportation and child care alternatives for mothers who have transportation or access issues
- Provide a hotline to help with issues of care coordination

Identify barriers to care from model of care:

- Physician payment structure
- Newborn eligibility process

- Explore claims processing issues that may affect data collection
- Educate physician about proper billing practices

Puerto Rico Measurement Plan

Measurement and Data Collection Strategy:

- Increase of at least 50% in PPC visits within the metro-north region
- Measurement period: May 1, 2014 through April 30, 2015
- Final reporting date (Close of project) August 31, 2015
- Baseline Data Year 2013
- Measurements are going to be performed on a monthly basis by claims data analysis and physician-reported data via the Quality Department
- An expected level of PPC visits was established based on 2013 utilization experience. Achievements will be measured based on cumulative utilization experience.

Process Measure

- % of women with appointment confirmation

Outcome Measures

- % of women with PPC visits within 21 – 56 days range
- % of women with no show

Puerto Rico Members Survey

The Puerto Rico team also conducted a survey of members in March 2014 in order to identify barriers to care from member point of view:

- Education
- Physicians' appointment system
- Social barriers (transportation, care of other children in the family)
- C-section follow up care

Source of data

- Women members of MiSalud (Puerto Rico Health Insurance) from the Metro North Region

Method

- Face-to-face interviews through the health educators

Profile of Members Surveyed
Age Range: 16-40 years
Median Age: 23.5
Characteristics of Birth:
• Vaginal (63%)
• C-section (28%)
• Did not respond to question (9%)

Puerto Rico Member Survey Findings

- 43% said they have the right knowledge of the period recommended for the postpartum visit.
- 73% said that their OB/GYN mentioned the importance of the postpartum visit .
- 75% reported that their OB/GYN described the appropriate date range for their postpartum visit.
- 58% of the members had a postpartum visit.
- 64% had their postpartum visit between 7 and 20 days.
- The main reason for postpartum visits in the appropriate time period was because of the education provided by the OB/GYN.
- The services received during the postpartum visit were:
  - Physical examination (90%)
  - Postpartum care (51%)
  - Family planning counseling (46%)
  - Weight control (31%)

Questions and Discussion

CMCS Maternal and Infant Health Initiative

A four pronged strategy designed to:

1. Improve the rate and content of postpartum visits; and
2. Increase use of most and moderately effective methods of contraception among Medicaid and CHIP beneficiaries

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Maternal-and-Infant-Health-Care-Quality.html

Wrap-Up Discussion

Now that the QI 201 Series is concluding, we welcome your reflections around the following questions:

- What do you think were the most valuable lessons learned throughout the series?
- What challenges and opportunities do you see in taking the next steps with your QI projects?
- What kinds of technical assistance or other support would be useful to your team going forward?

Thank You!

- Although the QI 201 Series has now concluded, you can still access technical assistance resources related to the Core Set measures by emailing the TA Mailbox:

  MACqualityTA@cms.hhs.gov

- To thank everyone for their engagement in the QI 201 Learning Series, we are preparing a Summary Brief with details about each team's project, along with a certificate of completion. Team leads will receive these materials shortly.