Using Quality Improvement to Determine Whether Your Medicaid Delivery System Reform is Effective

June 14, 2018
3:00-4:00 PM ET
A Few Quick Notes...

- To send a **text question**: Click the green Q&A icon in the lower left-hand corner of your screen.
- To view in **full screen**: Click full screen button in the lower right-hand corner of the screen.
- To return to the **original view**: Press the “Escape” key on your keyboard.
- For **technical support**: Click the “Support” option in the upper right-hand corner of your screen.

Please note that today’s session is being recorded.
Our Plan For Today

1. Learn or review **key concepts** of quality improvement.
   - What is quality improvement and the Model for Improvement?
   - Introduce the driver diagram as one important quality improvement tool.

2. Consider opportunities to **apply quality improvement** techniques and tools in your delivery system reform work.
   - What does effective implementation of quality improvement look like?
   - How can quality improvement help state Medicaid agencies like yours?

3. Find out **how to get started and use driver diagrams** in your Medicaid delivery system reform efforts.
Our Facilitators

Katherine Griffith
• Senior Advisor, Medicaid Innovation Accelerator Program (IAP)

Jim Jones
• Project Director, Medicaid Innovation Accelerator Program (IAP) Performance Improvement
• Former Deputy State Medicaid and CHIP Director
Our Guest Speaker

Dr. Mary Applegate, MD
• Medical Director, Ohio Department of Medicaid
• Pediatrics and Internal Medicine
What comes to mind when you hear the words “quality improvement”?

A. Performance reviews.

B. A broad term used to describe processes and tools to set goals, establish measures, select changes, and test actions.

C. I don’t have time for it.

D. All of the above.
What is Quality Improvement?

- The **processes and tools** to set goals, establish measures, select changes, and test actions.

- Quality improvement helps us to **identify and improve best practices** for delivery system reform.

- Our learning opportunities will align with the **Institute for Healthcare Improvement’s (IHI) Model for Improvement**.

![IHI’s Model for Improvement](image-url)
How Does Quality Improvement Help Your Work?

- Provides transparency and clarity
- Helps us “test” hypotheses around what works to drive improvement
- Enables meaningful progress tracking, measurement, and data-driven decision making
- Improves stakeholder and leadership buy-in
- Maximizes impact of funding and drives better outcomes

Life of the project:
- Project start-up and goal setting
- Iterative testing and project implementation
- Project outcomes
Quality Improvement Tool: The Driver Diagram

A **driver diagram** is a visual tool. It shows what contributes to an improvement aim.

The **aim** is a clearly articulated goal or objective.

**Primary drivers** are system components or factors that contribute directly to achieving the aim.

**Secondary drivers** are actions, interventions, or lower-level components necessary to achieving the primary drivers.
Building a Driver Diagram: Step-by-Step

1. Agree on the project “aim.”

2. Brainstorm all of the system elements, or drivers, that team members feel are necessary to achieve the aim.

3. Logically group the drivers and define high-level “headers” that summarize the groups.

4. Check the drivers for duplicates, clarity, missing elements, and team consensus.

5. Use arrows to show cause-and-effect relationships.

6. Define the interventions or strategies that the project will use to have an impact on the drivers.

7. Define project measures for tracking progress.

8. Review and update driver diagrams regularly.
Questions?

Please send us any questions through the text box feature.
**Smart Aim**
By July 1, 2016, decrease the rate of premature births in Ohio by 10% for those less than 37 weeks of gestation and by 10% for those less than 32 weeks of gestation.

**Global Aim**
Improve neonatal outcomes by reducing premature births.

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**Key Driver Diagram**

**Drivers**
- Early access to prenatal care
- Consistent and early recognition of prior preterm birth
- Adopt a cervical length ultrasonography screening protocol
- Expedite progesterone supplementation
- Customize patient care to start and maintain women on progesterone

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**Interventions**
- Screen women for obstetric history of preterm birth
- Align and communicate with emergency departments WIC, CHW, MCPs, and others to screen and refer when there is a history of preterm birth
- Facilitate rapid new obstetric appointments
- Postpartum counseling on progesterone for those eligible in next pregnancy
- Work with Medicaid and Medicaid plans to identify women at risk and reduce administrative barriers
- Create a written protocol for identified candidates
- Start progesterone as soon as possible (according to College and SMFM guidelines) after identification for eligible women
- Use ultrasonographers trained in cervical length measurement
- Develop a practice protocol to selectively or universally screen cervical length (consider population risk)
- Educate on benefits of progesterone and use evidence-based counseling methods
- Involve key support individuals
- Connect women to insurance, home care, social services, and pharmacies to ensure progesterone is available
State-level Progesterone Initiation Performance Improvement Project (PIP)

**SMART AIM**

- Improve the *initiation* of progesterone between 16-24 weeks gestational age from 15% to 30% by June 2016

**GLOBAL AIM**

- Reduce pre-term birth & infant mortality rates

**KEY DRIVERS**

- Accurate and timely identification (ID) of progesterone candidates (pre-pregnant & non-pregnant (prior pregnancy or not))
- Connectivity to Clinicians (consistent feedback, ID of high-risk (HR) women)
- Smart use of existing data sources
- Consistent implementation of the standardized clinical definition of Progesterone candidates
- Assuring high-risk pregnant women have access to High-Risk OB for HR pregnant women
- Pharmacy benefit: barriers & confusion as related to progesterone acquisition & administration (compounded vs brand name)
- Patient engagement and education

**INTERVENTIONS**

- Timely ID
  - Set up data systems in systematic manner for timely identification (vital stats data)
  - State to explore data use agreement with 3 main labs to ID pregnancy early
- Meaningful use of monthly data files
- Removal of barriers to 17p (prior authorization, paperwork requirements, lack of responsiveness)
- Consistent participation with Ohio Perinatal Quality Collaborative
- Direct connection with consumer (Text4Baby, etc.)

Revision Date: 01/28/15
**SMART AIM**

Improve the *initiation* of progesterone between 16-24 weeks gestational age from 15% to 30% by December 31, 2016

**GLOBAL AIM**

Reduce pre-term birth & infant mortality rates

**KEY DRIVERS**

- Accurate & timely identification of progesterone candidates
- Connectivity to clinicians
- Data support
- Confusion related to progesterone acquisition & administration (compounded vs brand name)
- Patient engagement & education
- Ensuring insurance coverage

**INTERVENTIONS**

- Standardized communication between provider & managed care plans (MCP)
- Meaningful use of monthly data files (e.g. redetermination file; vital statistics-claims linkage)
- Consistent & standardized clinical definition of progesterone candidates
- FAQ Sheet for providers re: Medicaid Redetermination
- Verification of insurance status at registration
- Removal of prior authorization on progesterone
- MCP assistance in managing eligibility continuity during pregnancy
- Provider education regarding 340 B pricing
- Provider education regarding progesterone coverage (FFS and MCPs)

**Revision Date:** 09/21/15

**Key**

- White box = Planned intervention
- Green shaded = What we’re working on right now
- Grey shaded = Completed interventions
**State-level Progesterone Performance Improvement Project (PIP)**

**GLOBAL AIM**
- Reduce pre-term birth & infant mortality rates

**SMART AIM**
- Improve the *initiation* of progesterone between 16-24 weeks gestational age from 15% to 30% by December 31, 2016

**KEY DRIVERS**
- Accurate & timely ID of progesterone candidates
- Build trusting partnerships
- Patient engagement & education
- Outreach to & involvement of unconventional partners
- Ensuring insurance coverage
- Rx acquisition & administration simplification

**INTERVENTIONS**
- Web-based Pregnancy Risk Assessment Form & Standardized Communication (PRAF 2.0) between Provider, County & MCP
  - Streamlined
  - ID of social determinants of health
  - Prescription
  - Home Health referral
  - MCP feedback to provider

- Meaningful use of data
- ID & appropriate follow-up for progesterone candidates identified prior to 16 weeks gestation (“early birds”)
  - Notification of County Department of Job and Family Services Pregnancy Related Services coordinators of member pregnancy to delay redetermination
    - Dedicated County staff & mailboxes

- Education around billing, acquisition & administration
- Coordination between Provider, MCP-contracted Home Health Agencies, & Specialty Pharmacy
  - Warm handoffs
  - In-office scheduling
  -- Combining calls for scheduling

**Revision Date:** 10.20.16

**Intervention Key**
- White box = Planned
- Green shaded = Current
- Grey shaded = Completed
Pregnancy Risk Assessment Form and Notification System (PRAF 2.0)

System Changes

- Develop System
- Medicaid Expansion
- Get everyone in the system
- Presumptive Eligibility
- Identify Risk
- Linked Claims-Vital Statistics Files to MCPs
- Provide Enhanced Services
- Enhanced Care Management
- Improve Communication
- Single “Skinny Form”
- Build Trust
- Removal of Prior Authorization
- Standardized Coverage

Ohio Department of Job and Family Services

- Serves as Home Health referral
- Serves as prescription
- Future applications (e.g., Home Visiting Referral) to be determined

Instant Notification
(Instead of fax or dedicated email box)

New MITS Role

Notifies the counties

Notifies managed care plans
Measures

• Outcome measure
  – The percentage of women eligible for progesterone who receive progesterone between 16 and 24 weeks gestational age

• Process measures
  – % of PRAF forms received that are still being faxed rather than completed online
  – # of days from ordering progesterone to receipt (home health injection, prescription filled, appointment made)—MCPs receive from contracted home health entities
  – # of pregnant women losing coverage during pregnancy
Percentage of Progesterone Candidates who Accepted Progesterone by Month (July 2015-March 2018)

MCPs begin notifying counties of pregnancy to reduce coverage loss

Removal of prior authorization on all forms of progesterone

PDSAs focused on coordination between Provider, Home Health & Specialty Pharmacy

Web-based communication form (PRAF 2.0) go live further streamlines communication between practice, county, MCP, & Home Health

Spread of change package

Improved ID of progesterone candidates < 16 wks gestation

Added Home Health Referral & Prescription onto communication form

MCPs begin notifying counties of pregnancy to reduce coverage loss

Percentage Initiating Progesterone

Median

July 2015 (n=7)
August 2015 (n=16)
Sept 2015 (n=16)
Oct 2015 (n=31)
Nov 2015 (n=22)
December 2015 (n=32)
January 2016 (n=49)
February 2016 (n=69)
March 2016 (n=38)
April 2016 (n=49)
May 2016 (n=69)
June 2016 (n=38)
July 2016 (n=54)
Aug 2016 (n=56)
Sept 2016 (n=64)
Oct 2016 (n=57)
Nov 2016 (n=56)
Dec 2016 (n=51)
Jan 2017 (n=54)
Feb 2017 (n=57)
March 2017 (n=54)
April 2017 (n=53)
May 2017 (n=57)
June 2017 (n=48)
July 2017 (n=81)
Aug 2017 (n=83)
Sept 2017 (n=95)
Oct 2017 (n=62)
Nov 2017 (n=84)
Dec 2017 (n=59)
Jan 2018 (n=87)
Feb 2018 (n=67)
March 2018 (n=63)
Process Measure Example: Percent of forms that are paper (rather than PRAF 2.0)

Percent of Forms that are Paper (rather than PRAF 2.0) by Week

- Median
- % of Practices Faxing Paper Forms
Lessons Learned

- QI tools like key driver diagrams (KDDs) are not static, but iterative
- Using the same standardized tools and language helps the effort/communication with multiple partners
- A one-page KDD helps parties see the work, including gaps, duplication, and parts that may not be assigned to the partner.
- Gaining deeper understanding of all the issues through QI efforts is helpful before developing policy (e.g., removal of PA for progesterone)
- The rapid cycle is weekly iterative testing and monthly data interpretation and broader discussion
Questions and Answers

What questions do you have for Dr. Applegate?

Q&A: What do you think?
How can your team get started?

These are a few questions we often ask teams that are new to quality improvement. Try taking these back to your workgroup or team:

1. What is the problem that we are trying to solve with this delivery system reform?
2. Who is the target population of improvements or changes?
3. What is the success that we hope to report to leadership and after how long (e.g. 2 years, 5 years, etc.)?
4. How will we know whether we were successful or not? What data or information would we look at to know?

Now it’s your turn! Try talking to your team about these questions and the other quality improvement ideas that we’ve discussed today!
Join us in September for Part 2!

Learn more about HOW we can use quality improvement in delivery system reform:

- What types of work might we want to use quality improvement?
- How can we begin measuring what is working and what is not?

During Part 2, you can expect to:

- Learn more from your other states’ experience using quality improvement tools and methodologies
- Learn how to use a driver diagram to develop an iterative testing or PDSA plan
- Discuss opportunities to use quality improvement in the work you are already doing
Thank you for joining! We want to hear from you!

- Complete the survey that appears at the conclusion of this event.
- Reach out with any additional questions. We are here to help support your learning.
- Let us know if you have ideas for additional quality improvement learning opportunities!