Centers for Medicare & Medicaid Services

Medicaid IAP National Learning Webinar: Diving Deeper into Driver Diagrams & Delivery System Reform Success Using Quality Improvement Techniques

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Operator: This is Conference # 2466623

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It is now my pleasure to turn today's program over to Katherine Griffith, senior advisor, Medicaid Innovation Accelerator Program. Katherine, the floor is yours.

Katherine Griffith: Good afternoon, everybody. First, I just wanted to really quickly welcome everybody to today's webinar around diving deeper into driver

diagrams and delivery system reform success using quality improvement techniques.

This is sort of a continuation of another webinar we held earlier this summer where we talked about the benefits of integrating delivery system reforms for states and had Ohio Medicaid present how they've used driver diagrams and the benefits to their program. So today we're going to dive a little deeper into driver diagrams, how to actually develop them, and we have Michigan on to share their experience.

So, I'm going to turn it over to the facilitators in Michigan to get us started.

Lindsay Parra: Thanks Katherine. Hi everyone, my name's Lindsay Parra. I'm working with Katherine on the Innovation Accelerator Program and specifically the quality improvement portion of that program. So like Katherine mentioned, we did meet earlier this summer and talked primarily about the great work that you can do using a driver diagram.

And our plan for today is to dive a little deeper and then review what comes after developing the driver diagram including measuring your progress, conducting iterative testing, and then based on what you learn about what works and what doesn't, update that driver diagram so that it's a continuously useful tool. I'm going to be joined later on the webinar by Jim Hardy, another one of our performance improvement subject matter experts, and he will also be speaking with our folks from Michigan.

So, before we get into that portion of the webinar, we wanted to do a quick refresher for anyone who missed that first session in June. So, what we're looking at now is the quality improvement journey and that journey starts by articulating an aim and then by identifying the primary strategies and interventions that's identifying drivers, the primary drivers and the secondary drivers. And then today we're going to talk not only about that process but also about selecting measures and conducting iterative testing.

And all this is really centered around one of our key tools of quality improvement which is the driver diagram. Again, that starts with developing the project aim and then by selecting those primary and secondary drivers.

Finally, then selecting project measures to understand which of those drivers are really helping us make progress towards that aim. And in a minute, we'll see a visualization of that driver selection process, but these are the kind of eight core steps of developing the driver diagram.

And there's a lot of brainstorming that goes on. Tt's a process that you want to include the entire team on and then again, it's a process that includes coming back to that driver diagram after you begin implementing your program as you begin tracking your measures and understanding which of those drivers are really working and which ones maybe need to be revised.

So, getting back to that first step because it's so important, what makes a good aim? A good aim has a vision that resonates and is meaningful. It's something that you can communicate with stakeholders and that you'll gain buy in. It's measurable and time bound, meaning that you can understand whether or not you're making progress and you have a date that you can hold your team to achieve that aim. And finally, it's ambitious; it's not something that you've already achieved or already making significant progress to. It's something that needs to happen and creates a big goal for your project team.

So, step two of that big eight step process is about brainstorming your drivers. So again, the primary drivers are the main core strategies and that's what is highlighted there in those two blue boxes those are your primary drivers. You might think about the barriers that you might face to accomplish the aim, that's one way of brainstorming those drivers. You might also think about what levers your state has to achieve that aim. Is there a financial lever, a policy lever? There's a lot of different things that you can think about to help decide how you might approach tackling that aim.

Are there other organizations or stakeholders that could help you accomplish the aim? Those are all options for selecting those primary drivers to help get you to your aim. And finally, are there other people who have accomplished the same in the past? Are there other states that have accomplished that aim that you could learn from or take suggestions from?

Steps three through five are really about brainstorming those drivers and grouping them together. So, the kind of visual that's depicted here is a bunch of different driver ideas. And it's not important to think at this point in step three about what's a primary driver or what's a secondary driver, the idea is to get it all down on paper. And the colors of these different drivers designate maybe some key topics that you're finding. Some you know when you start thinking about your drivers or start brainstorming some key topics may start emerging or key themes.

So, there might be a financial incentive theme. There might be a theme around patient engagement, maybe provider education. These are all things that may emerge as key themes when you start brainstorming your drivers and that's what those different colors can designate is all of those drivers that are blue or red or green or purple. They fall under the same key theme.

In step four, you might want try thinking about removing any duplicates. You may want to clarify any missing elements. Again, who are those stakeholders that you're going to be communicating with? Will they want to see a driver that includes their perspective? Those are all part of that step four process of clarifying the drivers.

And then step five, that's really when you get into the organization of your drivers. So again, you can think about those key themes that you identified those might be the more medium-term goals. Those are the kind of bigger concepts, bigger ideas. And then the short-term goals those might be more like short term interventions or short-term activities that your team may think about conducting in order to get to those medium-term goals.

So, one way that I sometimes read a driver diagram is from left to right or you can also read it from right to left. So, if you start with left to right starting at your aim, you might ask how? So how do we accomplish this big aim statement, this ambitious, measurable, time bound meaningful aim statement? You would then look to your medium-term goals. Those are probably how you're going to accomplish that aim statement. And then how would you accomplish those medium-term goals? Probably with those short-term goals activities or interventions.

If you were to read your driver diagram from right to left, you might ask why? Why are we doing these activities, interventions? Why are we trying to achieve these short-term goals? To get to the medium-term goals. And then finally, why are we doing those? To get to the long-term aim.

After we've gone through that really brief overview of the driver diagram development process, I wanted to also mention that we do have slides from the previous webinar that are available and that the recording of the previous webinar is available. And so, we encourage you to seek that out if you'd like more information on driver diagrams. But I want to hand it over to my colleague Jim Hardy for his work with the Michigan team.

Jim Hardy: So now we're going to kind of go into a real-life example around the driver diagram journey, and we're going to be talking about Michigan's driver diagram and their approach to it and how it evolved as the project and the analysis of the project developed and evolved.

And we're really pleased to have Sandhya Swarnavel who is the project lead in Michigan. And she's part of Michigan's Medicaid quality improvement and program development team and has been terrific to work with over the last year as we've been trying to refine the project. So, Sandy, welcome and why don't you start by just talking about why you and your team were interested in participating in the children's oral health value based payment opportunity?

Sandhya Swarnavel: Good afternoon Jim and good afternoon everybody. In Michigan you know we were actually doing a procurement for the Healthy Kids Dental program, and we were looking at really overhauling the whole program and making a very vibrant quality based program. And we had big ambitions, and we still do, and we wanted to incorporate a new contract requirement with one percent withhold.

And we thought it was a good time to apply for this technical support and get the necessary support to make this program better and have all the resources which is being offered to us by the IAP team in collaboration with the IBM Watson and Deloitte team. So, this was the prime reason why we applied for this proposal.

Jim Hardy: Thanks Sandy. So how familiar was your team with quality improvement before we started the project?

Sandhya Swarnavel: In Michigan we have a wonderful managed care program. It's been in existence for a long time. We are familiar with working with all the physical health plans and the concepts of managed care, but the challenge was to translate those principles specific to oral health. We have a long way to go for quality in oral health and this is not unique to Michigan. This is a national issue where we are trying to catch up with the physical health programs and we are trying to introduce quality based initiatives.

But the good thing is that the IAP team, many of the people in the IAP team, we are housed in the managed care under managed care in one area under the leadership of a division director Kim Hamilton. And we have an overall quality vision which we would like to align with which is being put forth by Tom Curtis who's a manager for quality section. And I translate that quality strategy and apply it mainly to how that translates into oral health initiatives.

And when we need help with contract languages to make those possible and to use those quality initiatives we use Sheryn Johnson who's a contract specialist. And once a contract is written - and you know we actually celebrated this week, our new quality initiative Healthy Kids Dental program with a new contract and for this fiscal year. And we now are going to be depending on our colleagues in the plan management section who have you know - Heather Lubinsky, who manages the plan management and Arkim Mohnaiky, who's a contract manager who makes sure that the language and all the requirements are met by the plans.

And then also when we need data to monitor to look at how we're improving for our metrics, we have colleagues in the actuarial division led by Penny Ruttledge and Matt Schneider who help us with our data needs. And for our guidance for the policy side of things we have Cindy Lynne and Kyle Nordnan from the health policy. So, we have all the resources and more where we have the IAP team. So, we are hopeful that we are going to make the most of it in trying to reshape the program. Jim, over to you.

Jim Hardy: Sorry Sandy, I was talking on the mute button. I think it's really great how you've pulled together a team. Your program people, your data people, your contract people all working together as you head down this new path around quality improvement for your dental program. So Sandy, why don't you tell us about the actual payment project?

Sandhya Swarnavel: Yes, basically the aim is to reduce emergency department utilization for non-traumatic dental issues among children in the Healthy Kids Dental program. And in Michigan the healthcare delivery is based regionally and we have 10 prosperity regions. And so, when we did the data analysis, we found that region four needs a lot of improvement and we found that we had emergency visits which was one of the most number over there. So, we needed to address that and see if we can make a real improvement.

But what we also wanted to do is also use the contract language of one percent withhold and see if we can implement a pay for performance program. And this year what we are planning to do is do a shadow monitoring of the process and develop our methodology for the program. and then once we develop the incentive program and we revisit, and we see if anything needs to be changed, if things are working, not working. And once we have everything put in place and it looks good, then we would like to introduce one percent withhold for next year.

So, this is what we are planning and we also are planning in this process to implement a dental home and administer oral health risk assessment. And also, as part of the quality measures we are planning to use CMS for 16 annual dental visit measures, the heated measure, and also some of the DQA measures like usual source of service or continuity of services. Such measures are going to be part of the process, but the overall focus is going to be on preventive measures and that's what we are hoping to achieve is to increase the preventive utilization.

Jim Hardy: Thanks Sandy. Sandy what part of the state is region four in?

Sandhya Swarnavel: It's actually on the western side of the state, it's lower western side. It's areas and counties like Mecosta, yes Calhoun, and those areas. So, there

are a few counties which are going to be in the lower southern part of the state.

Jim Hardy: Cool, thanks. So, when we started the driver diagram development process, how did your team find the that exercise of developing that firm aim statement? Can you talk a little bit about how that process went?

Sandhya Swarnavel: So, for the driver diagram, the first aim statement, is that what you're talking about Jim?

Jim Hardy: Yes, yes.

Sandhya Swarnavel: OK. So, you know developing the first aim statement we had to decide on the priority of the program, what was important to us and as managed care and what we are doing in the whole state on the physical health side and how we can align with those goals and ambitions.

So, once we decided on who the target population is going to be and what kind of improvement we want to make, we have to also now be realistic about how much improvement we want to see. What are feasible goals to have and because it takes time to move the numbers and therefore the target set should be feasible. We started with different target populations first, but when we did all these steps which Lindsay was talking about for the eight-step process for the driver diagram, we realized that we had to change the target population.

So. once we decided that, we wanted something tangible, something that we could measure the change. And you know Medicaid health plans pay for emergency visits including dental in Michigan. The Medicaid health plans, they're working on initiators to reduce the emergency visits, but it did not involve the dental health plan for Healthy Kids Dental because that's a carve out for the children.

And so, we wanted everyone to have taken the process and see if they can be collaborating to for the outcome to happen all over the state. And so, we decided this would be a good initiative to have.

Jim Hardy: You know Sandy, one of the things that struck me when we were going through this process, it was really kind of interesting with our initial driver diagram we were focused on kids who were in the out of home placements. And what I thought was really interesting about that process is that it really kind of forced the team to really engage with that system. And then we learned a lot about that system and then recognized that some of our initial kind of views of that population were -- needed to be changed and kind of led us here.

So, I thought it was kind of an interesting kind of process - really had us engaged with folks who we normally might not engage with in the Medicaid program.

Sandhya Swarnavel: Yes, yes.

Jim Hardy: Did you kind of feel the same way about that?

Sandhya Swarnavel: Yes, initially we started with the initiative with the 4E departmental reward program which is actually a federal program with Medicaid children under the foster care agency. And because it was Medicaid managed care and these children were under the Healthy Kids Dental program, we decided to take this up as a population because we found that there was a lot of improvements being made when we looked at the data and we were using our data warehouse here in Medicaid.

But as you know, this population has an inherent quality of where people are in and out of the program. And so, what we found is when we involved the stakeholders or foster care agency in the process - which I should say it was a little later in the journey that we decided to involve them because we wanted to figure out the workflow process. And when they were brought in, we found out that there was a difference in the data quality and where the data had to be validated between our system the Medicaid data warehouse and their system.

And so, because this was a two-year initiative and we had very less time to make all this happen, we decided that since we were putting dollars into this program through this particular population, the departmental ward program is of priority. And it's still something that we want to continue working on, but it

may not be something which we would want to do for this particular project. So, once we knew that, we had to change our aim. We wanted to make sure that we found something which we can make an actual difference and that's when we decided to work on the emergency department utilization data.

And though we had used up a few months of our time in this process with the departmental ward program, we think it's good because we have found that there is an issue with the data and because they are not validated with their system. And so, we need to do that. And also, we have a communication channel which has been established with that agency which was not existing before. So that's what we learned from this process is to involve all your stakeholders as early as possible so that we can determine the feasibility and see what values exist and work through the workflow process.

Jim Hardy: Cool. So, when we changed aim, what kind of changes did that generate throughout the driver diagram?

Sandhya Swarnavel: So, once we paint the aim, you know in the driver diagram, it had led to all the other changes because we had to find out what kind of changes would be needed in the whole system to make that aim possible. So, we decided and focus on particular outcomes which is the aim statement and then from there we had to figure out how we could get there which are the primary drivers, so we had to change that.

And then we had to figure out how those primary drivers are connected to the secondary drivers which drive the primary drivers to get the necessary outcome. So, everything had to be changed. And I don't think this is going to be the last time we do that because as we move forward with the next project or with a different aim, we also were in the process of starting the new contract with the new vendors so we had to involve them in this process.

And we had the vendors come in and they have input which we need to incorporate to make it work for everyone. And to operationalize it, we would have to depend on them. So, this is going to be a constant change in process and it's going to be changing as many times as we need.

Jim Hardy: It's a very interactive and iterative process as we've learned over the last year. We've talked a little bit about testing and measures right now Sandy, so in the project, what part of that driver diagram are you most focused on for testing?

Sandhya Swarnavel: We at this moment have left the aim statement. We are still putting in the numbers as to the target rate of what would be our target which we want to achieve and what is the time which we want to do. So that needs still to be decided and defined, and that would be done by looking at data and that's something which we want to look into and we'll be working through the process.

And the other thing is we are focused on the secondary drivers which are the steps needed to operationalize this. And we are focused on activities associated with these secondary drivers which involve basically mainly two entities. One would be the state where we have activities, where we facilitate the conversations. We put forth the measures for measuring this performance for pay for performance measures.

And the dental vendors will be focused on developing a process to identify the target population on how are they going to get this data. Are we going to give it? Are they going to ask us? Do they have access to those systems which other Medicaid health plans have? Because, as I said before, the bills are paid by the Medicaid health plans and so how does that happen? Who gives data and how do they collaborate? So that needs to be worked out.

Also, we need to develop and define what a dental home concept is and how are we going to measure the health risk assessment process. What tools we are going to be using? So, we have to focus on all these steps which lead to the primary drivers. And from there we have to also look at the data and work on that.

Jim Hardy: And one of the other things Sandy that you'll have to think about is what measures are you actually going to put in the one percent withhold? You know you're tracking a lot of different measures but the things that you actually put in the one percent are going to be, I think, key to driving the kind of change that you're looking for.

Sandhya Swarnavel: That is absolutely correct. We have all these three different types of measures which you were talking about, the process measures, the balancing measures, and the outcome measures. So, we have to think through what kind of measure would be used in the incentive program and how we are going to define it and what are the codes which are going to be used and what is the frequency with which we would be measuring this? So, a lot of decisions have to be made.

Jim Hardy: Sure. Can you talk a little bit more about the types of measures? You know you started just a second ago kind of talking about the types of measures, but as you're thinking about how you're going to do like iterative testing, what types of measures might you use and incorporate iterative testing?

Sandhya Swarnavel: Yes, for example, for process measures we're talking about how many health risk assessments have been administered. So, what we need to do is develop the specification for the measure. Are we going to use the existing health risk assessment tool? Are we going to modify it? Who uses this tool? How do we collect the information and then what do we do with this information?

So, we have to make all those decisions because that would help us to have those specifications done in such a way and the process figured out so we have to make those decisions. And then the second type of measure is the outcome measure. For example, measuring the rate of preventable emergency dental utilization. Again, for those we need to develop the specifications, inclusion and exclusion criteria, and the codes which are going to be used.

Do we measure overall or look at sub-populations of interest? Are we looking at specific regions? So, those kind of things, and are we looking like in terms of trend analysis. So, those kind of decisions have to be made. And then for balancing measures, a good example would be like the rate of timely treatment for preventable dental care among those assigned to a dental home. So here, for this measure we need to first define what a dental home means and then how do we assign the dental home. What do we mean by timely treatment what kind of time are we looking at?

So, we have to make all these kinds of decisions and have a workflow and we have to validate the data and test the process and test the frequency when it is collected and modify it accordingly. So, once we have figured out all those, then we can use the one percent withhold to incentivize the plan for providers.

Jim Hardy: Sandy, if you had to look into your crystal ball, where do you think - most likely as we do the iterative testing - that you will end up making changes to the driver diagram?

Sandhya Swarnavel: Oh, I think as we do the iterative testing, depending upon what kind of results we get, we have to see whether the process works. It can be operations issue. Tt could be that we have implemented all these steps, and still we are not seeing results, whatever that may be. We might find that the data is moving very slowly. Maybe we have to take a second look at the aim statement.

So, we might have to do whatever it takes in terms of this iterative testing and look at all the different things. So far, we have discussed the initiatives which we have started with our dental vendors so we have brought them in. Now we also have to find out how we are going to talk to the provider community and how the vendors are going to help with this process. We have to assess their readiness.

We have already assessed the readiness of the vendors, but from the providers, how enthusiastic are they about this process and what we are going to do to make that happen. We have to review the data to determine our target population, intervention, and approach. So, we have done that. So, looking at the aim specification of the target rate needed for the definition, what does success mean to Michigan? So, what does it mean when we say that we have this aim and we have this approach? What are we looking for?

And we have to also establish work groups, facilitate discussion among the different stakeholders, and also, we are going to be doing shadow monitoring for this year and make some adjustments to the process. So, once we do all this, we will look at the driver diagram and see how we can reflect all these changes and whatever they may be, we have to incorporate them.

Jim Hardy: Thanks Sandy. So, Sandy, overall have you found in using the quality improvement approach, using the driver diagram approach, can you talk a little bit about how the team has found it? Has it found it useful? Just your general kind of thoughts about it.

Sandhya Swarnavel: Sure. It's been a very interesting process in Michigan. As I said with the new quality program, with the new contract, now we have a new vendor. We had one vendor before, now we have two vendors and the other vendor starts with zero enrollees, so how are we going to incentivize the other plan and make sure that we take that into consideration?

We need to figure out what kinds of standards are set for these measures? We can look at the historical data, but again is that applicable to the current situation, to the new contract and the new vendor? And also, we can take a look at the national standards and we can look at the case studies and see if they are applicable to Michigan. There's a lot of work to be done and I think we are just getting started here. But luckily, we have you and the whole IAP team to guide us through this process and we also have the states who had done this already.

So, we would be looking towards all of you to guide us through this process.

Jim Hardy: Well thanks Sandy, we really appreciate you taking the time to kind of walk us through the Michigan journey. It's been fun for the first year and I'm sure we'll have a fun and interesting ride for the second year too.

Sandhya Swarnavel: Thank you, thank you for this opportunity Jim. Thank you everyone.

Jim Hardy: That's great. So now we're going to shift on the agenda and just wrap up by talking a little bit about iterative testing and start to talk about why we conduct iterative testing. So, one of the first things we want to be able to use iterative testing for is to understand which of our strategies are moving closer to our aim and which are not. And they really kind of fall into two aspects.

So, one of the things we're trying to look at is, are the strategies that we put in place being successfully implemented? So, if we said, for instance in

Michigan's example, we're going to institute dental health, we're going to need to look at the pickup rate. How many kids are actually being assigned to those dental homes? Has that initiative actually been successfully implemented?

And then the second part of it is that we need to look at if that strategy having the intended impact. We had a hypothesis that if we did this, X would happen. Is that actually happening? It also allows us to determine where to invest more, or less of our time, and money, and resources. So, if we're able to say boy, this strategy is really working and maybe we could actually enhance its effectiveness by putting more resources there, as opposed to another strategy which we thought was a good idea at the time, but as we look at it, it's not generating the kind of results. Maybe it was harder to do.

So, it kind of gives us that sense of what's not working and then also what do we need to change and modify in our strategies and making sure that we're continuing to invest in the stuff that's working to achieve our aim. It also helps us to provide evidence to support our strategies when we're talking to stakeholders. You know particularly when we're talking to them about changes, and how folks are getting paid, and we're talking about outcome measures. Being able to communicate and communicate regularly with your stakeholders keeps them invested in the initiative.

And by doing the testing and having a concrete plan, we'll make better decisions. We'll have stronger rationale, and it'll allow for that the continuing testing to modify and improve the strategies that we put in place. So how do we conduct iterative testing? Once we've finished the driver diagram, we need to create a plan that helps organize the measures, look at our data resources, look at our questions. And then once we've come up with that plan, making sure that we're meeting on a regular basis to track the results, talk about program updates, data updates, all those types of things.

That plan needs to include what measures we're going to use, what testing steps we're going to use, data collection techniques, data analysis techniques, and timelines that'll allow us to create our overall plan. So, if we can move to slide 20, we can look at sort of what that testing, iterative testing template, might look like. So, we'd look at our measures, and then we'd look at the

frequency, and we'd look at our data sources. We'd look at, you know like I said, the actual measure and the key questions that we're trying to answer through the testing.

So, if we're looking at a bundled code for instance around the dental home, are we using it? Are more providers using it more than others? So that may lead us to, boy we've got some providers using a new code to identify folks with a dental home, others aren't. Do we have to now do more outreach and communication?

So, it kind of gives us a path to being able to study it, and those early kind of process measures give us a real opportunity to kind of have early warning indicators about things that may or may not need to change. And then we look at measures that might have a longer timeframe. Things that you might look at like every six months, or annually. While those can be process measures, they also tend to move toward like outcome measures, because you want to have a good basis of time to be able to analyze whether there's been movement or not.

So, we can go onto how this kind of plays out like in real life. We kind of created a little example here of what a meeting might look like for your team, where you might meet on a quarterly basis, and you'd have your data folks and your program folks, and your quality improvement folks all together in the room where you're analyzing the data, looking at the reporting out on the measures that you've picked, identifying trends, and then talking about the implications of those trends on the actual operation of the pilot.

So, then the quality folks can talk about the implications, and maybe we need to add measures. Maybe something in the data's saying boy, we need to look at this, we hadn't looked at this before. So, it really gives you a chance. The more frequently that you meet to be able to refresh, identify, modify, and change not just your program, but also your testing plan. Your testing plan can also be an organic document as you learn more and more about the initiative, about your hypothesis, and what you learn from the data.

So, you know, it may end up like in Sandy's case where you may be looking at one of those meetings where we're thinking about so, what's happening across our pilot region four? And the data folks are telling us, well, there's been an increase in enrolment in dental homes and the utilization of preventive services in the last quarter. That's really good information for the program folks to use as they continue to implement the initiative.

And then it also allows the you know your Performance Improvement lead to be able to say boy, okay so this data it looks like good results, but do we need to change anything in our driver diagrams? For example, as a result of the analysis that we've done through this last testing period? So, Lindsay, I'm going to turn it back over to you.

Lindsay Parra: Yes, great. Thank you, Jim. I want to let Christina remind folks how to ask questions. And certainly, feel free to ask questions about any of the content that we've covered today on driver diagrams or iterative testing, but also please feel free to ask Sandy a question about what she and her Michigan team are doing.

Operator: At this time, we would like to take any questions you may have for us today. To ask a question via the web, click the green Q&A button in the lower left-hand corner of your screen. Type your question in the open area and click submit.

Lindsay Parra: Great, thanks Christina. And we do already have one question. What is the appropriate or average time for conducting iterative testing? This will likely depend on the defined scope, but is there an average time period one should follow?

And I'll let Jim and Sandy talk more about the time period for conducting that type of iterative testing. But I'm sure you all have also heard of rapid PDSA (Plan, Do, Study, Act) cycles, and that's I think when we expect to see more frequent PDSA iterative testing. For instance, a clinical environment where you're testing a specific, maybe care protocol or intervention.

But Jim, any guidance on iterative testing in a state Medicaid environment?

Jim Hardy: Well, I think the frequency is really driven by what you're actually trying to look at. So like if you're looking particularly in the beginning, you're looking at process measures. Then I think you want to do that more frequently because you're trying say boy, is the activity that we wanted actually happening? And so, I'm going to want to do that very frequently early on in the process.

And then less frequently, I'm going to want to look at the impact of that because I want to look at that impact over time. And so again, it kind of depends on where you are on that looking process as opposed to looking at outcomes to how often you might visit a particular measure.

Lindsay Parra: Great, thanks Jim. I think another question that I see here is, is there a maximum number of drivers the driver diagrams can have, or is there any guidance on how crazy that driver diagram can start looking?

Jim Hardy: You know, there's no like maximum limit. The states that we work with tend to kind of think about the primary drivers, maybe three to five, just because I think you're trying to look at the things that you think are the most key to moving an initiative. And I'm kind of a simple guy, so in my teams I tend to say, let's pick our three and then inevitably I get negotiated up to like three, four, or five as the team begins to think about the initiative and sort of the totality of what aspects of the delivery system and the ecosystem that the initiative intersects with.

Lindsay Parra: Thanks, Jim. I think the only thing that I would add to that is that when selecting your drivers for the driver diagram, I think one thing that the Michigan team thought about and some of the other state teams that are developing value based payment models are thinking about is, it's not just that financial incentive driver but ,what are the other drivers that you will need to get to that aim?

Because Sandy mentioned that there are a lot of things that could potentially go wrong, and I wouldn't want a team to assume that maybe their VBP (Value Based Payment) model isn't working when really, it's patient engagement that needs to be worked on, and the VBP model is actually functioning as it should. So, something to think about. You don't need to necessarily be

collectively exhaustive in the drivers, but certainly think about outside the immediate project focus.

Sandhya Swarnavel: Also, Lindsay, I just wanted to add - this is me, Sandy from Michigan - I just wanted to say that it also matters as to what the model of care is and whether it is a managed care system or whether it is a fee for service or those kinds of things whether it's a carve in, whether it's a carve out. How many stakeholders we are talking about? In managed care, we look for the plans, we make them work to get their incentives.

So, they do the outreach, they have to build the system and those kinds of things. So, it might depend on so many factors I think.

Lindsay Parra: Great. Thank you, Sandy. Thanks for adding that. And thanks for everyone who asked questions and for everyone who joined our webinar today. We're going to be pushing out a survey immediately at the close of our webinar and we hope that you're able to take just a few minutes to respond to that survey and let us know what we're doing right and what we're not doing right.

We try to incorporate quality improvement techniques into all the work that we deliver through the IAP program and so your feedback is essential in helping us improve for next time. So please respond to that survey and again, thank you so much to Jim, to Sandy, to Katherine, and to all of you who were able to join today. Have a wonderful day everyone.

Sandhya Swarnavel: Thank you.

Lindsay Parra: Christina, could you please push the survey?

Operator: Thank you. Thank you to all our participants for joining us today. We hope you found this webcast presentation informative. This concludes our webcast and you may now disconnect. Have a great day.

END