CMS Quality Improvement Workshop Series
QI 101

Webinar 2: Developing Aims and Selecting Change Strategies

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Agenda

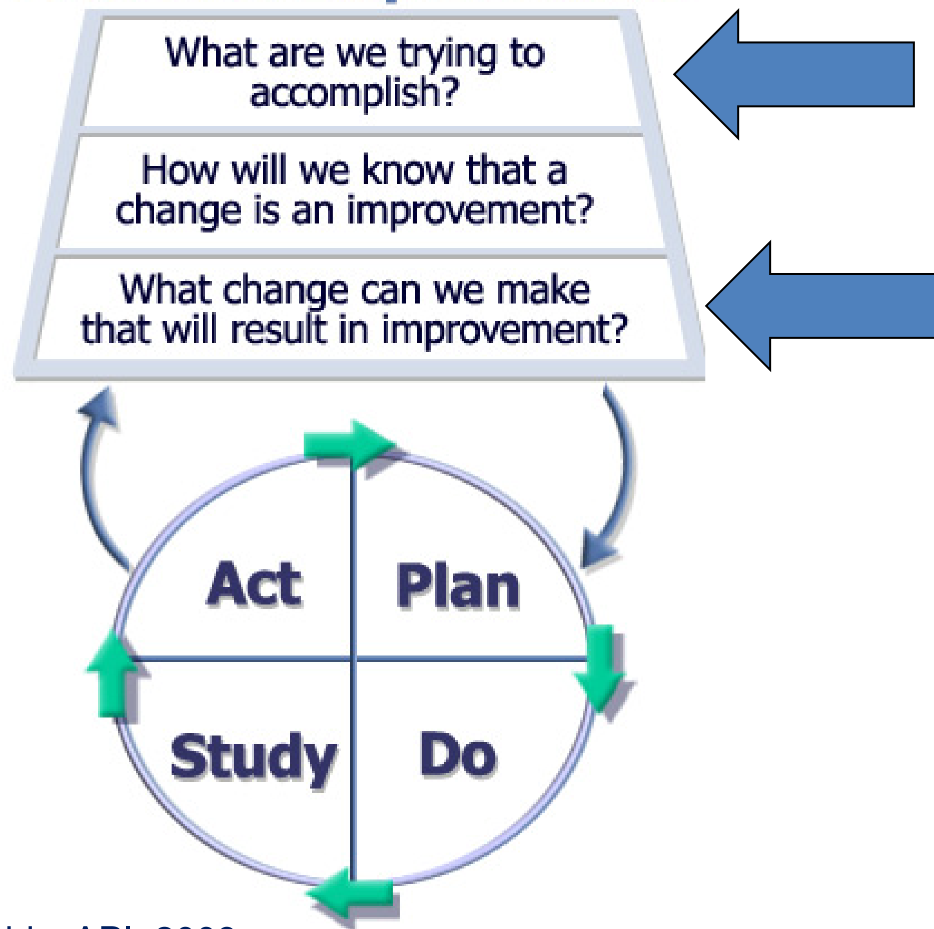
- Welcome and Introductions
- Purpose and Learning Objectives
- Recap of Webinar 1: Selecting a QI Project
- Developing Aims
- Selecting Change Strategies
  - Selecting Primary and Secondary Drivers
  - Linking Drivers to Plan-Do-Study-Act (PDSA) cycles
- Question and Answer
- Preview of Webinar 3

Purpose and Learning Objectives

- Purpose: Enable state Medicaid and CHIP staff to improve child and adult health care outcomes using the Model for Improvement
- Participants will learn how to:
  - Put into practice two of the three questions of the Model for Improvement:
    - What are we trying to accomplish?
    - What changes can we make that will result in improvement?
  - Connect driver diagrams to best known theory as a way to organize change strategies
    - Link the driver diagram to interventions or PDSA cycles
    - Identify and assess promising change strategies and related interventions

Recap from Webinar 1: Selecting a QI Project

The Model for Improvement



Source: The Improvement Guide, API, 2009

Factors to Consider in Selecting a QI Project

- Priorities related to the "Triple Aim"
  - What will improve the health care experience of those in our state?
  - What will improve the health status of those in our state?
  - What will reduce the cost of care in our state?
- Where are the biggest health disparities?
- Where does the will to improve exist?
- Who can execute change?
- What interventions exist that will get results?

Useful Data in Selecting a QI Project

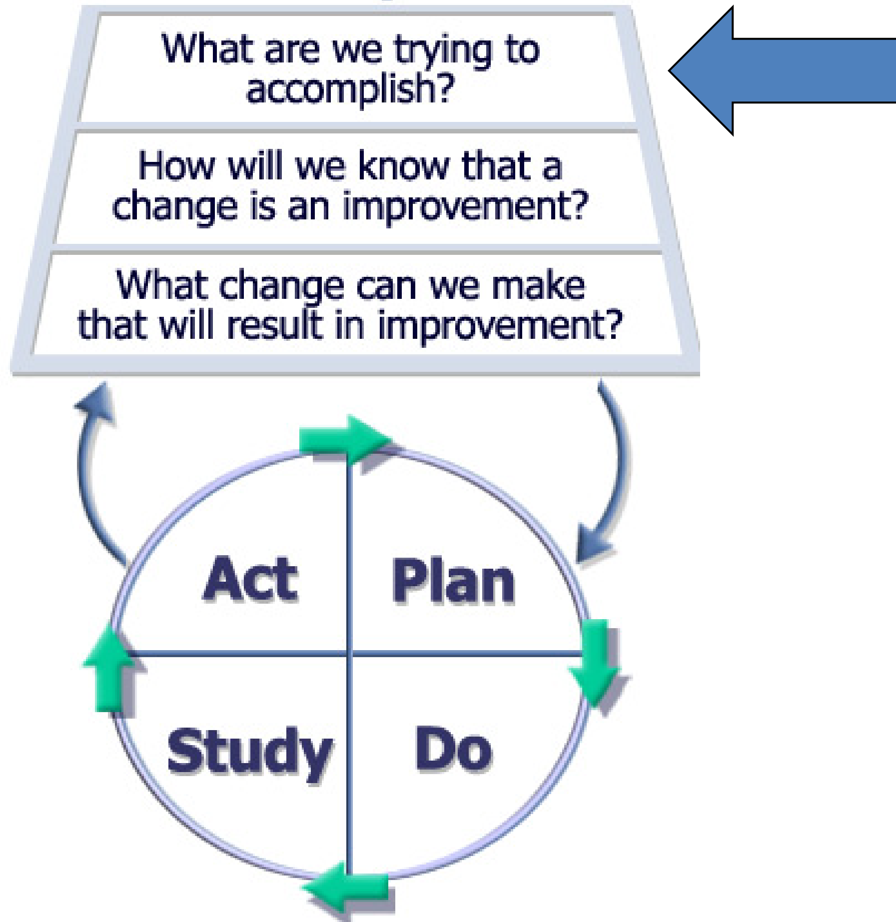
- Medicaid and CHIP program expenditure data (top diagnosis, utilization, cost drivers)
- Claims/encounter data, health record reviews
- Pharmacy data analysis
- Referral patterns and supply driven demand
- Child and Adult Core Set measures (past performance)

Please Complete the Poll on the Right Side of Your Screen

- Question: Where is your state or program in terms of starting a QI project?
- Responses (choose one):
  a. We are curious about QI but we are not ready to commit to a project
  b. We are committed to doing a project but have not selected a topic
  c. We have picked a topic for a QI project but we have not started
  d. We have picked a topic for a QI project and our team has started working on it

Questions?

Developing Aims



Source: The Improvement Guide, API, 2009

Question 1: What are We Trying to Accomplish?

Developing the Aim Statement

Tips for Constructing an Aim Statement

- Involve state and stakeholder leaders
  - Obtain sponsorship (geared to the project's complexity)
  - Provide frequent and brief updates to key stakeholders and sponsor (practice the 2-minute elevator speech)
- Focus on issues that are important to your state
  - Connect the team's aim statement to the state's priorities
  - Build on the work of others!

Create a Strong Aim Statement

- The aim statement should be easy to remember
- Include:
  - What will we improve?
  - For whom?
  - How much?
    - Specify number goals for outcomes
  - By when?

Aim Statement Example #1

Over the next 12 months, we will reduce all cause readmissions for Medicaid beneficiaries by 10 percent.

Focus Your Aim Statement

"Some is not a number, soon is not a time!"

Don Berwick, Institute for Healthcare Improvement (IHI)

"Here is what I think we should do.
I think we should save 100,000 lives.

And I think we should do that by
June 14, 2006—18 months from today.

Some is not a number and soon is not a time.
Here's the number: 100,000.
Here's the time: June 14, 2006—9 a.m."

Aim Statement Example #2

- Over the next 24 months, we want to improve care for children, youth, and adults who have asthma so that:
  - ED visits related to asthma decrease by 25 percent or more
  - Hospital admissions related to asthma decrease by 15 percent or more
  - 90 percent or more are immunized against flu each year
  - 50 percent or more have BMI assessed and receive advice on achieving healthy weight
  - 50 percent or more of those who smoke are offered smoking cessation programs

Checklist for Aim Statements

Aim Content

- Explicit overarching description
- Detailed goals (How much?)
- Time specific (By when?)
- Define population of interest and participants

Exercise: Evaluating Aim Statements

Aim Statement	Is this a good aim statement?
We aim to reduce admissions to hospitals for enrollees in Medicaid Managed Care Plans.	
We will improve screening for depression and follow up.	
Our Consumer Assessment of Healthcare Providers and Systems Health Plan Survey scores are in the bottom 10 percent of the national comparative database we use. As directed by the Commissioner, we need to get the score above the 50th percentile.	
We will increase referrals to Alcohol and Other Drug Dependence Treatment for our people who are eligible for dual coverage by 25 percent within the next 12 months in 3 pilot counties of our state. We will achieve less than 2 percent recidivism rate after 1 year of discharge.	
Our most recent data reveal that on average only 35 percent of children and youth receive dental treatment services. We intend to increase this average to 50 percent by 12/1/13 and to 75 percent by 6/31/14.	

Aim Statement Worksheet

Project Name: ______________________________

Aim Statement:

What will we improve? ______________________

For whom? ________________________________

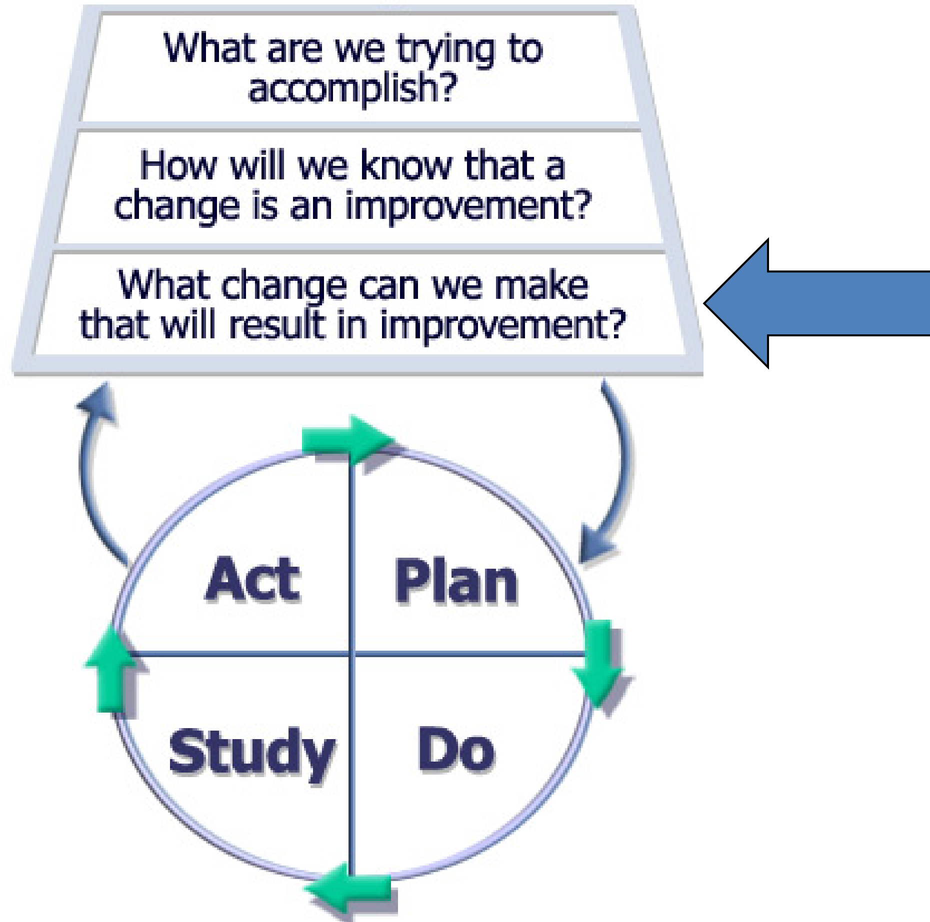
How much? ________________________________

By when? _____________________________

Questions?

Selecting Change Strategies

Question 3: What Change Can We Make?



Source: The Improvement Guide, API, 2009

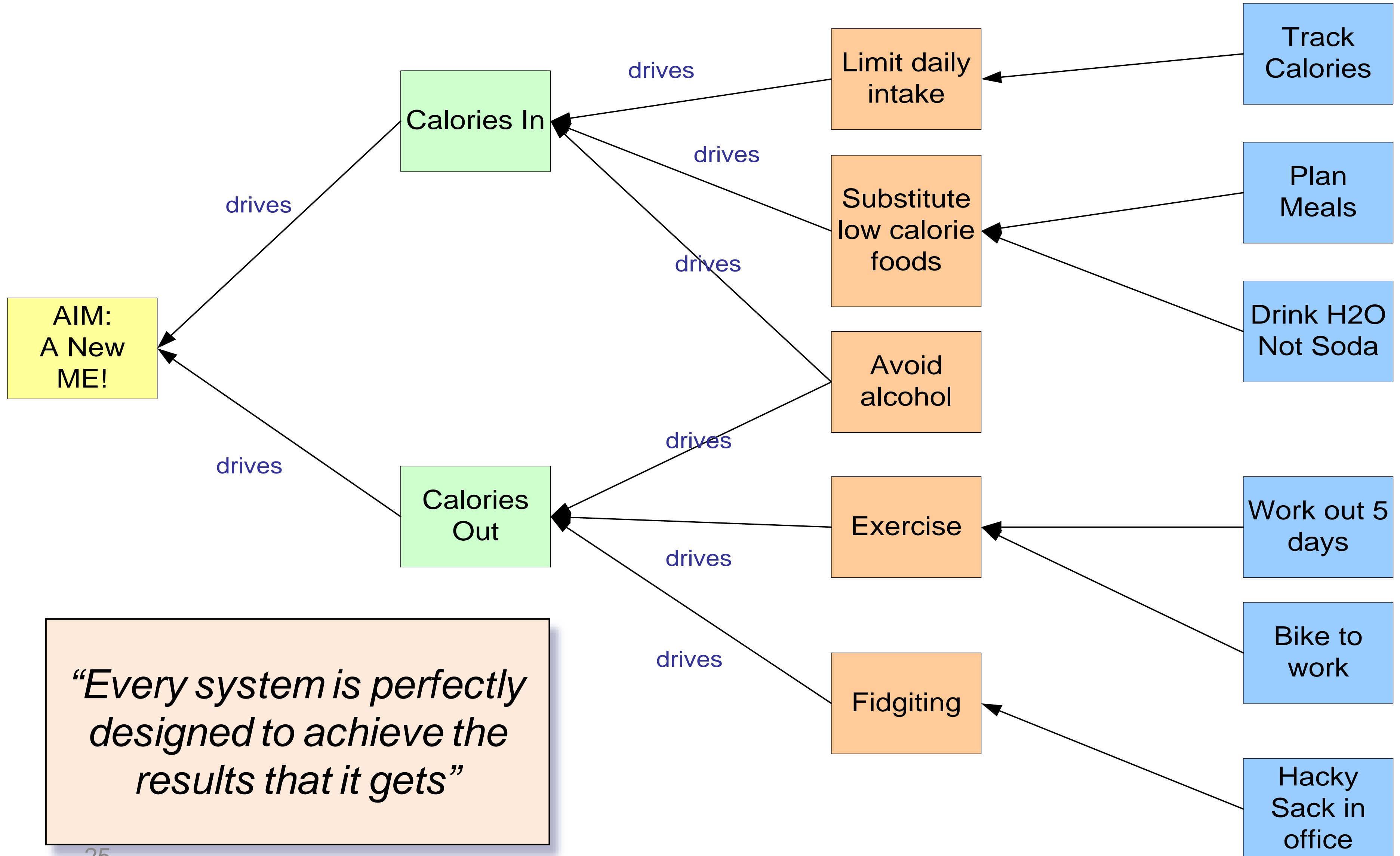
What is a Driver Diagram?

- A tool to help us understand the system, its outcomes, and the processes that drive the outcomes.
- It represents the best theory we have to get results!

Two Types of Drivers

- Primary Drivers
  - System components that will contribute to improving outcome(s)
- Secondary Drivers
  - Elements of the associated primary drivers that help create changes
  - Interventions expected to affect primary drivers and thus outcomes
    - Evidence-based: clinical or other types of evidence
    - Necessary and sufficient for improvement

A Theory of Weight Loss



Where Do You Get Ideas for Changes to Put in the Driver Diagram?

Experts

- They help assess evidence.
- They have experience with process interventions that will get results and move the primary drivers.
- They help define outcome measures and identify the processes to measure.
- They know what is both necessary and what is sufficient to achieve results.

Evidence

- A collection of good ideas ready for use, based in research and best practice.
- Ideas that are ready for use when piloted and shown to get improvement.
- Examples: clinical guidelines, algorithms, and standards of care.

Sources for Change Concepts

- State Medicaid, health plan, and university experts
- Quality improvement organizations and external quality review organizations
- Federal agencies (e.g., CMS, AHRQ)
- Partnership for Patients website
- HRET-HEN website (driver diagrams, measures)
- Professional societies (e.g., American Academy of Pediatrics, American Academy of Family Practice, AcademyHealth)
- Other organizations (e.g., IHI, NICHQ, CHCS)
- Listservs

How Do I Select the Categories for a Driver Diagram?

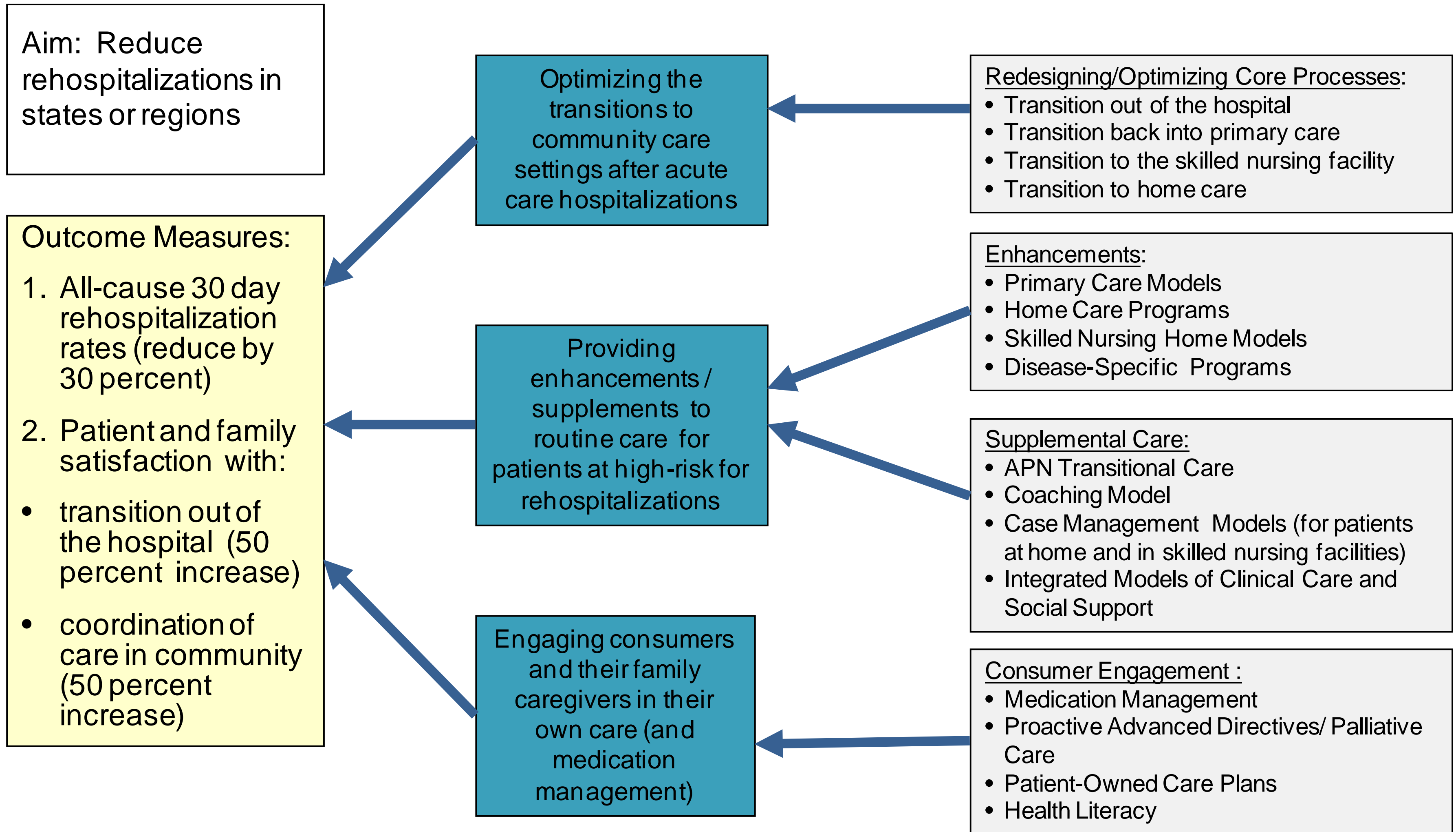
- Start with your theory of what it will take to get results
- Think of the changes necessary to bring this about
- Categorize these changes into groups that make sense
- Then ask: Is this change necessary to get results? Is it, when combined with all the others, sufficient to get the results we seek?

Oral Health Example

- Ideas in no particular order: early preventive care, regular dental check-ups, a dental home, timely treatment, self care, swish and swallow, separate tooth brushes, brushing at school and day care, sealants, fluoride varnish
- Begin to see groups or categories of primary drivers
  - Self Care: swish and swallow, daily brushing, brushing at school, my own toothbrush
  - Dental Home
    - Prevention: regular cleaning, regular visits, fluoride varnish, sealants
    - Treatment
  - Access to Care (emerged as a potential primary driver as we created the categories)

Questions?

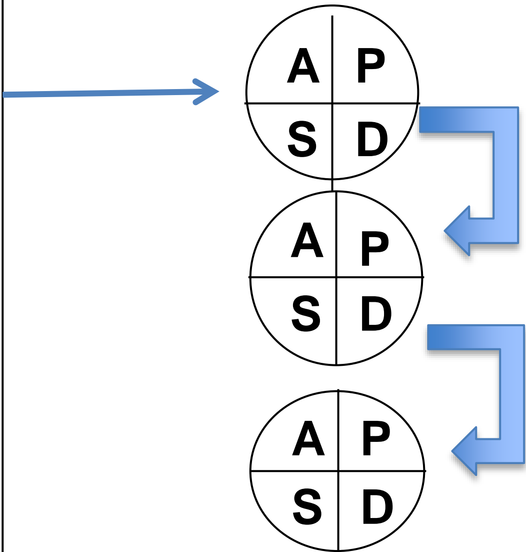
Interventions for Reducing Rehospitalizations: IHI and Commonwealth STAAR Program



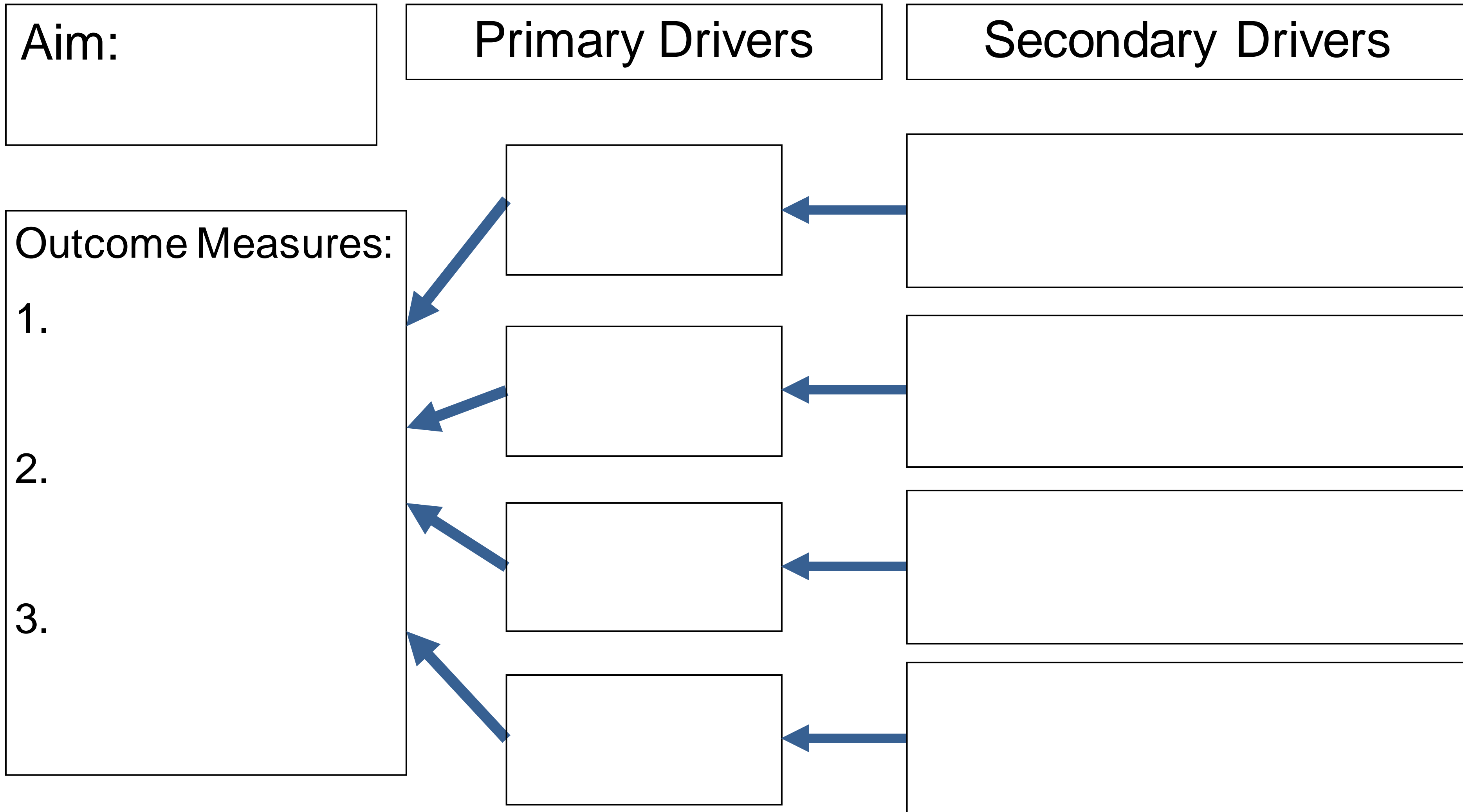
Medicaid/CHIP
Health Care Quality Measures

Linking Drivers to Interventions and PDSA Cycles

Aim: By Dec. 2014, we will improve transitions in care for people who live in our community. One primary driver is to reduce readmissions.

Primary Drivers	Secondary Drivers/ Interventions	Tests of Change
Reduce admissions and readmissions	• Identify patients in hospitals and post-acute settings at high risk for readmission • Integrate self-management skills into care transition planning in all settings • Use multi-disciplinary teams to actively coordinate care across the continuum • Enable appropriate and timely follow-up with providers and community resources after discharge from acute and post-acute care settings • Develop and promote best practices, tools and training, and recognize high performers • Implement payment incentives • Align QI projects to reduce admissions and re-admissions with contract tasks and funding • Measure and report readmission rates	

Driver Diagram Worksheet



Medicaid/CHIP
Health Care Quality Measures

Continuing Education

- Continuing education (CE) is provided jointly through Tufts University School of Medicine Office of Continuing Education and the National Initiative for Children's Healthcare Quality
- CE credit available for this three-part webinar series includes:
  - 2.25 AMA PRA Category 1 Credits™
  - 2.25 Contact Hours for nurses
  - Certificate of participation
- Attendance at all three webinars is required to receive full credit
  - Sign in for Webinar 2: http://www.cvent.com/d/bcqvxh
- Certificates will be available electronically 6 to 8 weeks after successful completion of Webinar 3

Next Webinar in the QI Workshop Series

- QI 101, Webinar 3: Measuring and Monitoring Improvement
- When: April 29, 2013 - 2:00pm to 3:00pm ET
- Purposes:
  - An in-depth look at applying Question 2 of the Model for Improvement: How will we know a change is an improvement?
  - How to use Plan-Do-Study-Act cycles to accelerate improvement and get results

Questions?

Thank You for Participating in Today's Webinar!

Please complete the evaluation as you exit the webinar.

Medicaid/CHIP
Health Care Quality Measures

Appendix

Jointly sponsored by Tufts University School of Medicine and National Initiative for Children's Healthcare Quality

Accreditation

Physicians

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Tufts University School of Medicine (TUSM) and National Initiative for Children's Healthcare Quality. TUSM is accredited by the ACCME to provide continuing medical education for physicians.
- TUSM designates this enduring material for a maximum of 2.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses

- Tufts University School of Medicine Office of Continuing Education is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's COA.
- This activity provides 2.25 Contact Hours for nurses.

Requirements for Successful Completion

- To receive CE credit, participants must register, view the content and complete the evaluation. Certificates will be available electronically 6-8 weeks after successful completion of the activity.

Disclosure of Relevant Financial Relationships with Commercial Interests

- All faculty course directors, planning committee members and others in a position to control the content of an educational activity are required to disclose to the audience any relevant financial relationships with commercial interests. Conflicts of interest resulting from a relevant financial relationship are resolved prior to the activity during the content review.

No relevant financial relationships are held by any of the planners, presenters or TUSM OCE staff.

Additional Resources for Developing Aims and Selecting Change Strategies

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

Agency for Healthcare Research and Quality: http://www.ahrq.gov/health-care-information/topics/topic-quality.html

Quality Improvement Organizations : http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/

External Quality Review Organizations: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Partnership for Patients: http://partnershipforpatients.cms.gov

Hospital Engagement Networks: http://hret-hen.org

American Academy of Pediatrics: http://www.aap.org

American Academy of Family Practice: http://www.aafp.org

AcademyHealth: http://www.academyhealth.org

Institute for Healthcare Improvement: http://www.ihi.org

National Initiative for Children's Healthcare Quality: http://www.nichq.org

Center for Health Care Strategies: http://www.chcs.org

Child and Adolescent Healthcare Quality Improvement: http://www.nichq.org/online_communities/listservs.html

2013 Core Set of Children's Health Care Quality Measures

Prevention and Health Promotion
Timeliness of Prenatal Care
Frequency of Ongoing Prenatal Care
Behavioral Health Risk Assessment (for Pregnant Women) – ***NEW IN 2013***
Percentage of Live Births Weighing less than 2,500 Grams
Cesarean Rate for Nulliparous Singleton Vertex
Childhood Immunization Status
Adolescent Immunization Status
Human Papillomavirus (HPV) Vaccine for Female Adolescents – ***NEW IN 2013***
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment
Developmental Screening in the First Three Years of Life
Chlamydia Screening in Women
Well-Child Visits in First 15 Months of Life
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Adolescent Well-Care Visit
Percentage of Eligibles Who Received Preventive Dental Services
Availability
Child and Adolescent Access to Primary Care Practitioners
Management of Acute Conditions
Appropriate Testing for Children with Pharyngitis
Percentage of Eligibles who Received Dental Treatment Services
Ambulatory Care: Emergency Department Visits
Pediatric Central-line Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
Management of Chronic Conditions
Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits
Medication Management for People with Asthma – ***NEW IN 2013***
Follow-Up Care for Children Prescribed Attention Deficit-Hyperactivity Disorder (ADHD) Medication
Annual Pediatric Hemoglobin A1C Testing
Follow-up After Hospitalization for Mental Illness
Family Experiences of Care
Consumer Assessment of Healthcare Providers and Systems 5.0H (child version including children with chronic conditions supplemental items)

Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

Prevention and Health Promotion
Flu Shots for Adults Ages 50-64
Adult BMI Assessment
Breast Cancer Screening
Cervical Cancer Screening
Medical Assistance With Smoking and Tobacco Use Cessation
Screening for Clinical Depression and Follow-Up Plan
Plan All-Cause Readmission
Diabetes, Short-term Complications Admission Rate
Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
Congestive Heart Failure Admission Rate
Adult Asthma Admission Rate
Chlamydia Screening in Women age 21-24
Availability
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Prenatal and Postpartum Care: Postpartum Care Rate
Management of Acute Conditions
Follow-Up After Hospitalization for Mental Illness
Elective Delivery
Antenatal Steroids
Management of Chronic Conditions
Annual HIV/AIDS Medical Visit
Controlling High Blood Pressure
Comprehensive Diabetes Care: LDL-C Screening
Comprehensive Diabetes Care: Hemoglobin A1c Testing
Antidepressant Medication Management
Adherence to Antipsychotics for Individuals with Schizophrenia
Annual Monitoring for Patients on Persistent Medications
Family Experiences of Care
CAHPS Health Plan Survey – Adult Questionnaire *with* CAHPS Health Plan Survey v. 5.0H
Care Coordination
Care Transition – Transition Record Transmitted to Health care Professional