

Centers for Medicare & Medicaid Services

Medicaid IAP National Learning Webinar: Using Quality Improvement to Determine Whether Your Medicaid Delivery System Reform is Effective

June 14, 2018
3:00 p.m. ET

Operator: This is Conference # 3586335.

Operator: Hello, and welcome to today's webcast. My name is Emily and I will be your event specialist today.

All lines have been placed on mute to prevent any background noise. Please note that today's webcast is being recorded. During the presentation, we will have a question and answer session. You may ask questions at any time by clicking the green Q&A icon located in the lower left-hand corner of your screen. Type your question in the open area and click submit.

If you would like to view the presentation in a full-screen view, click the full screen button in the lower right-hand corner of your screen. Press the "Escape" key on your keyboard to return to original view. For optimal viewing and participation, please disable your pop-up blockers.

And finally, should you need technical assistance, as a best practice, we suggest you first refresh your browser. If that did not resolve the issue, please click on the "Support" option in the upper right-hand corner of your screen for online troubleshooting.

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

Katherine Griffith: Okay, thank you and I wanted to just quickly welcome everybody to today's webinar with the CMS Medicaid Innovation Accelerator Program, the webinar is using quality improvement to determine whether your Medicaid delivery system reform is effective.

And just want to welcome everybody and say we're really excited about today and hope that this is a great learning opportunity for state Medicaid programs as you're thinking about your delivery system reforms and where to start.

We at the Medicaid Innovation Accelerator Program, usually start with goal setting and thinking about how delivery system reform is going to address what we want it to using tools like driver diagrams.

And so, we're going to recap that a little and then have a great conversation with Dr. Mary Applegate from the Ohio Medicaid Program about how they have used this quality improvement tool in their delivery system reform efforts.

So, I'm going to pass it on Jim Jones who will be presenting and facilitating that discussion. And feel free to ask questions throughout. Jim?

Jim Jones: Yes, hi. Thanks. Thanks, Katherine. My name is Jim Jones. I'm a consultant at Deloitte Consulting. Right now, I've been working with CMS and Katherine and the great team of folks at CMS on the Medicaid Innovation Accelerator Program.

And just to give you an idea of my background on Medicaid, I spent 31 years at the state of Wisconsin working the Medicaid program. The last 4, I was the Deputy State Medicaid and Chief Director.

I've spent the last 7 years being a consultant on State Medicaid and I've been working with states. I've been working with people like Katherine of CMS. I've gotten the opportunity to work with some non-governmental organizations and with some health plans.

So, now you know who I am. Today, as we look at this, we want you to learn about some key concepts of quality improvement, and what is it, what's the model for improvement, and re-introduce the driver diagram which is one of the important quality improvement (QI) tools we'll talk about.

We're going to consider some opportunities to apply the proper QI techniques and tools where you work today, and really talk about effective implementation, and what that looks like with QI, and how the QI approaches health state agencies like yours.

Right now, we're working with a whole bunch of different states across the country. We worked with other ones before that on QI in the Innovator Accelerator Program. And I can tell you it does really work. You find out how to get started in new driver diagrams in your Medicaid delivery system reform effort.

First, let me introduce our speaker who we're going to talk to, send you some background slides. I want you to know who Dr. Applegate is.

She serves as a Medical Director for the Ohio Department of Medicaid, and she's responsible for Ohio's Medicaid Quality Strategy and getting that implemented. She is double boarded in Pediatrics and Internal Medicine. And she's in a rural primary care practice for over 30 years, and she's still now caring for newborns and mothers.

Her social interests include the application of those clinical principles in QI science to health systems, to improve the quality of healthcare and health outcomes. She is instrumental in driving change in perinatal health, change for opioid prescribing, and integrating behavioral healthcare.

So, very happy to have Dr. Applegate on. And we're going to go through one of the projects which she did QI on in a moment. But we thought we'd start off by getting an introduction of quality improvement. And one way to do that is to really set a baseline.

So, we're going to have a poll now, and we'd like you guys to participate so we have our baseline data to see how we did at the end of this.

So, 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." And D, "all of the above."

So, just take a moment here and put in your answers and we'll see how this all will turn out.

Ok, I hope you had a chance to enter your results. Can we see the results now?

So, we got 87.2 percent. I'm glad that we're going out to that particular degree of accuracy. It's important to know it's a broad term used to describe processes. Some people do think it's about performance reviews. The problem with the term quality improvement is it's sometimes doing small things.

I'm glad nobody said that they didn't have time for it because you're taking time on this webinar today. And the 4.3 percent are also kind of right in this fact that it's "all of the above".

So, let me talk about quality improvement for those of you who maybe haven't been introduced to this as others. It's the processes and tools to really settle, establish measures, select changes, and set actions.

So, the idea is you identify what you're trying to accomplish and then you use these tools as a way of trying to identify your goal. And then there's also a way of identifying what you actually need to change. What interventions or activities do you need in order to see that improvement?

And then it's also about really using those tools to test out your ideas and see what works and what doesn't. And that's part of the Plan-Do-Study-Act. The cycle that you go through, we call that iterative testing and that's what we're talking about.

The model we work from in this project is one from the Institute for Healthcare Improvements Model for Improvement. So, we use the driver diagram, what you can see on slide. Move on, slide eight.

Also, how does quality improvement help your work? And as we talked about it, it really does provide transparency and clarity. If you know where you're going and what things you need to do to get there, you can measure this as you go along. You can have a lot of transparency and clarity. So, you can talk to people about it.

It also helps you test the ideas that you have for how you're going to improve your process, your policy, your system, whatever it might be. How are you going to get to that goal that you're aiming for? And you can test to see which things are working and which ones aren't.

It also enables meaningful process tracking measurement and data-driven decision making. And one thing I want to say about that is many times when I was in state government, and even since, we sometimes start with a solution rather than our actual goal.

And what we found with quality improvement is you actually know what that goal is. Where do you actually want to be in two years, three years, six months? Whatever the time period, I want to be able measure that progress as it's going to lead to a more successful outcome.

It's going to put you in a place also where you can be measuring quantitatively and qualitatively how far you've come in your work. Not just to the outcome, but how you'd actually move through the steps of quality improvement. So, you aren't just checking boxes and things. "Yes, change the system. Yes, Change the notice. Yes, we trained everybody."

You're actually looking out and looking for measurements that it's how well you train people, how well that message has gotten out there, how well the implementation effort is actually doing. So, it actually maximizes the impact that you're funding and it drives you to better project the outcome.

On the other end of the spectrum, when you're building it and as you're moving it forward, it really does improve stakeholder and leadership buy-in, in part because it's an aspirational goal that you are aiming for. It's something that you can talk to and be simple about.

But also, it gives you all something that you have in common, a goal that you're all going for, and I think solidifies your stakeholders much more than other approaches.

So, the major quality improvement tool that we used is the driver diagram. Now, the driver diagrams, you can see it right here, it's made up of boxes, as you can see. It can be read left to right or right to left.

What it starts off with though is aims. As I was saying, an aspirational goal that you have, an objective that you have, what you're aiming for and we want that aim to be quantifiable so you could measure it. And we also want it to be time limited, so we know, "by such and such a day, I will be this much improved in what I'm trying to do."

And as we look, to the right of that are primary and secondary drivers. But primary drivers are groups of interventions and activities and system components that contribute directly to achieving an aim.

When I'm working with groups I always start off with, "if I don't do this, we won't reach the aim," is what would be our primary and also secondary drivers are the things we absolutely need to do in order to be successful.

And then the secondary drivers, which we grouped into the primary drivers, are the actual activities that you do, the interventions that you have, any of the

lower level components that lead to bigger things that you need to accomplish in order to, in the end, achieve your aim.

The idea here is also to think about those strategies that you're doing to achieve your aim. And as you move this forward, the driver diagram is very much a living document. It's something that you move back and forth to, as you move through your project. You look back at it, you review it, and you see if things are working.

Sometimes you're right and sometimes you're wrong. Sometimes you have to adjust your strategy in order to reach your aim within the time frame that you first described. So, it gives you this opportunity to test those hypotheses.

So, if you were going to build a driver diagram, as we are going to show on slide 10, you need to agree on a project aim. You need to brainstorm all of the system elements. You need to logically group stuff together. You check for duplicates, things that are missing. You get team consensus.

You use arrows to show the cause-and-effect relationships. You define those interventions. You define the measures that you're going to use to track progress and you're going to review and update those drivers.

As we talked about it, it's the living document so that you can go back to it and review how you're doing and test your hypotheses and your strategy to see if they're working and adjust it accordingly.

So, that's a very, very, very fast introduction to quality improvement. There's a lot more to it. But it's the idea just to give you sort of an introduction to it and a basic understanding. So, we want to see if anybody has any questions at this particular point.

Katherine Griffith: So, thank you, Jim.

Jim Jones: Ok.

Katherine Griffith: This is Katherine again. So, we do have a few questions that came in for you. The first one, “does the order of the drivers matter and are all drivers supposed to happen at one time?”

Jim Jones: No, absolutely, not. You know if they can, they don’t have to. It’s the order of importance, but not in this particular exercise that we go through. It’s not really not time or size that are important. It can be done any way.

There will be threads through those drivers that happen well before other threads. You might be completely through one primary driver and just getting started on some of the other secondary drivers for other threads in the diagram.

Katherine Griffith: There is actually a question about the 10 steps. Can we go back to the the previous slide?

Jim Jones: Yes, yes.

Katherine Griffith: In terms of what activities you can do to determine the drivers you’re selecting?

Jim Jones: I’ll start at a little bit different place. One of the things that you need to agree on is an aim and that really involves, “Who are the people that I’m trying to impact? What’s my target population?”

Second, “What am I trying to improve on health outcomes, costs, whatever that might be, customer satisfaction?” And three time-limits.

Once you have that, let’s talk about everything that we think we’ll need to do. We put up on the board, and we just brainstorm the heck out of it. We write them all down.

And then the next thing, after we’ve written them all down, what will be all the activities? “Oh my gosh, we’re going to have to change notices. Oh my gosh, we have to train people. Wow, we have to go over here and do this.”

Once we have all those things, we grouped them together so that we kind of have headers and those headers usually become the primary drivers. And we're able to put that driver diagram together.

Usually, then we talk about how the arrows go. And does this arrow go to box one, and box two, and box three, or to just box one and box two? So, we do a lot of talk like that.

Katherine Griffith: Great. Thank you. That's all the questions we have. As you guys hear the next conversation, we encourage you to ask questions in the chat box.

And also, I want to just note really quickly that these steps are the steps that CMS has worked and works by and they are actually published. There's a publication about how to develop a driver diagram if you just Google "CMMI driver diagram development".

So, I know people are interested in this and "how to's", so there's a lot of resources out there. So, now, I'm going to pass it back to you Jim to talk with Dr. Applegate.

Jim Jones: And we're so lucky to welcome Dr. Applegate to the webinar at this particular point. We're going to start off on slide number 12, which describes the Progesterone Project clinical diagram that they put together in the state of Ohio for their Medicaid program.

And Dr. Applegate, again, thank you for being here. Can you start by telling us a little about your decision to begin using quality improvement and delivery systems efforts like this?

Mary Applegate: Sure, good afternoon everyone. Greetings from sunny Ohio. So, thank you for letting me come talk to you about this because within our Medicaid program, we certainly have had a shift in how we see our work.

I will acknowledge that Ohio is an expansion state. And to that end, we became more and more aware that we're really in the business of population health management.

And what improvement science tools do is they give us a framework through which to operationalize real improvements, as opposed to the old way of identifying a problem and then putting a program in place and then trying to find evidence that the program was or perhaps was not creating the results that were desired.

So, what happened in Ohio, which is similar to other states, is we recognized that we had this massive issue related to preterm birth and most specifically related to African-American preterm birth disparities.

Even though access to care was available throughout the entire state, we actually had a worsening of our results. So, it was not just about access to care, it was access to the right care and it was access potentially to progesterone for women who are at risk for preterm birth because they already had a prior preterm birth.

So, what we wanted to do was to take this clinical opportunity to scale through the managed care plans who actually know that the members exist. We have a linked file with vital stats in Medicaid. They have a seven-year history of who is at risk, and we thought we could actually do something without having it take 20 years. So, for us, this was a great example to try to that and figure it out.

So, we have a prenatal quality collaborative as well and they constructed what they saw all the pieces were, and that's what you actually see on the slide here.

And to them it was all clinical. There was early access to care, finding high risk people, recognizing who the women were. If they hadn't had a prior preterm birth, do a cervical length, so you can find the women who may have their first preterm baby. And then facilitate the provision of progesterone throughout the course of their pregnancy.

So, those were the main drivers and how those developed, that was one of the questions. You get in the room and a good

way to elicit what some of the issues are is to ask people what frustrates them about it.

So, a lot of clinicians understand what's supposed to happen and then they have all these reasons for why not. And that's actually a really good way to get to what it is you're trying to solve for realizing that the very first step is agreement about the goal.

So, the goal for us was with a very specific reduction in 10 percent of births less than 37 weeks. And we had plenty of evidence, so there does have to be a theory behind this. There's plenty of evidence that progesterone reduces preterm birth particularly those less than 32 weeks.

So, you can see this is very clinical. The only thing they thought we could help them with was removing barriers. So, in that green box you can see that was just a very small part of the effort.

So, this was very helpful because everybody starts using the same language about what we're talking about. So, I'm not sure if we want to pause here or if you want me to go on to the rest of the story.

Jim Jones: No. I think we should look at the next slide. Because, I think what we want to do is sort of take people through the evolution.

Mary Applegate: Ok.

Jim Jones: So, you're using Q. in other efforts in Ohio today and you continue to use it across the Medicaid agency?

Mary Applegate: Yes. So, what we did is we realized that the plans really were focusing on managing risks according to eligibility categories, whether or not they were aged, blind, or disabled, or in the ABD population, and that doesn't necessarily translate to making sure that people at risk get evidence-based care.

So, our first step was helping them understand who's in our program and then specifically, as it relates to this, who is at risk for preterm birth. And we did

start with the clinical definitions of who may be a candidate for progesterone realizing that we needed the clinicians to agree.

So, we were happy to have a perinatal quality collaborative that actually defined that for us. And we all at the managed care plans agreed to use the same definition. So, that was really helpful.

Jim Jones: So, Lindsey, can you move this back to slide 12. I skipped this forward too fast.

Mary Applegate: So, then what we did is while the clinicians were working on their part, which related to practice level types of things, we had a parallel effort with our Medicaid managed care plans.

As you may know, we have federal requirements around doing performance improvement efforts. And we use the same language and the same types of tools to actually look at managed care plan operations to see if we could have parallel processes. And then, like the rungs of a ladder, just tie these two things together and then we could go forward faster.

And what you'll note is in the first box. We all agreed on the identification, but what happened is the managed care plans had no idea who was pregnant at that time, so they were very ready to remove barriers but they didn't know for whom.

We asked the clinicians if they could tell us who the women were and they had no way to do that, because prior to this time, they had no reason to contact the plan whom they did not perceive as being helpful in the good care of their moms.

So, we had a lot of work to do just in that communication space. And making it easy to communicate, who is at risk and making it fast to communicate so that we knew there was some urgency to this. It was super important.

Normally, on these key driver diagrams, we color in green the ones we're actively working on. You'll notice for this one, we have it circled in green so that you can still read the print. But the reason that's helpful is we may delineate seven or eight issues but only really be working on three.

So, here you see it circled. On other slides you'll actually see it colored if we were able to change the font.

I don't know if you want me to pause there.

Jim Jones: No, no. I think it's really good. I mean, one of the questions I think, people are going to have is when you talk about who is in the room putting this together. Who is identifying the drivers and the interventions? The order the things would happen in? Was it you and the managed care plan? Then other the chief medical officers? Did you guys agree on where you're going right from the outset, or did it take a while to sort of storm and norm through to get to an aim?

Mary Applegate: Well, since you asked, one of the main things that happened when we started this is Medicaid was blamed for being the barrier. "You're the reason our moms can't get what they need." So, perhaps it started in a less collegial way.

But really these are documents that help you have the same conversations. When it gets into the operations of a specific practice or the managed care plans, there's a little bit of protection around it. But we all had a common view of what it was we were working on.

So, we got to the communication and trust levels that we could tell them what we thought they needed to do clinically. Like, "hey, if you have twins or triplets, that's not an appropriate use of progesterone."

And then they could tell us what they thought, like, "hey don't make a stiletto out of a piece of paper," for example. So, these are done ideally by the entire team of people in the effort and that's important.

Jim Jones: Well, I noticed this as we went through these slides earlier, that the driver diagram seems to shift. It seems to change. How and why did it change over time?

Mary Applegate: Yes. So, we have to recognize that on the key driver diagram on the very right-hand side says “interventions”. And even in the key driver part, these are all theories as to what’s going to move your measure.

And as you get into the work and learn. there are some things that are rabbit holes that don’t actually move the dot that you’re trying to get to. And so that’s actually how it changes or you advance the work.

And generally, what we find is these earlier diagrams, we actually end up simplifying the diagrams with fewer words because by then everyone understands what you’re talking about. But in the beginning, you have to define all of your terms and whatnot. So, that it’s all in one piece of paper essentially.

So, you’ll see that these are all dated so that you can tell. If no one has taken notes, you can just put up your key driver diagrams in chronologic order and have an understanding of what you learned and what changed. So, that’s useful as well to capture the experience

Jim Jones: That is fascinating as the words get simpler. It’s a really interesting thing to talk about. We’re going to move on to slide 14 and ask you about this updated version of the driver diagram. What did you learn through that trial and error process?

Mary Applegate: Well, I think the most important thing we learned is number one, the clinicians communicating with the payor turns out to be very, very useful. And in the beginning, all the practices wanted to use facts.

So, in Ohio, there are between 65,000 and 70,000 births a year. Doing that many to managed care plans is untenable and then they wonder why the plans don’t have information. That’s a crazy way to do it.

If you just have one or two patients that’s, actually okay. But taking it to scale is a whole different thing. So, we ended up developing a simplification of what information needed to be conveyed, so really boiling it down to the very basics.

And there are two things we want to know. One, is who is the person? How can we reach them? And what do you need? So, it's not all 72 risk factors in the ACOG pregnancy risk assessment form.

So, we boiled that down to one and a half pages essentially that then became a web-based tool that then simplified what they needed to do. They didn't then need to call the plan, they need to call the specialty pharmacy. They didn't have to call the home health person. They didn't have to call all these other people just related to trying to get progesterone to happen. So, the communication simplification was super, super important after we already did the identification of the women.

And then, the next thing is the blaming and judgment thing. It is pretty interesting. If the system is so complicated, we don't have to divide people into friends and foes, just simple confusion is actually enough to not be able to go from the desire to get progesterone to actually getting it.

So, ending the confusion through communication was actually very useful. And we tested what they wanted us to. We removed prior authorizations. And it turns out the most important lesson here was that's a tiny, tiny barrier compared to all of the chaos in these women's lives.

And what really happened is when women were sick, if they were (inaudible) with their pregnancy around, especially if they had other children, they were unable to go to the county to notify them of their pregnancy status so that they would not fall off the Medicaid program.

And so, we were losing high risk women because they fell off Medicaid altogether. All the doctors knew was that they didn't come at the office. What they didn't realize is they were in the Medicaid program, so they didn't have contact with the managed care plans either.

So, when we realized that we told the managed care plans, "when the doctor tells you that they had a high-risk pregnant person, it's your job to tell the county so that they don't fall off the Medicaid program." And that single

thing is what resulted in an almost 20 percent improvement in preterm birth rate less than 32 weeks related to this effort.

So that's part of the discovery. And you notice nothing about this system was part of the original theory. So, you notice that none of that is actually part of the prior theories. But that's actually what we learned, what we learned here. It wasn't just all of the problem around progesterone. It was this very last box ensuring insurance coverage turned out to be the linchpin to success.

Jim Jones: It's amazing how much they will attest those ideas and what you learn over time. So, this thing that I'm absolutely sure was going to move the needle, there's nothing in this we hadn't thought about or we thought it was a minor thing, ends up being kind of a linchpin as the whole thing. This is a great example as states do this, this idea of a living document.

This idea that the Plan-Do-Study-Act cycle, iterative testing, is so important. And then, to adjust your strategy, your interventions so that you could be successful, that focused on the prize you aimed at the end is still important.

So, we're going to move on to slide 15. Can you walk us through some of the major system level changes that you made and where you ended up? What does the program look like at this point?

Mary Applegate: Yes. So, I think that's actually the news flash. Do you remember the prior key driver diagram was all about this clinical stuff. It turns out that the O.Bs could not teach how to do cervical length measurements accurately to their residents and the women really had to go to radiology.

Radiology schedules are already full. That ended up being a huge barrier in trying to identify that 15 percent with their first time preterm birth. And so, essentially, we abandon that entire thing.

So, it was 99.9 percent clinical. And the thing that made the difference was the system. Making the system change to have women not fall out of the system was the single most important thing, as was the communication, which was this web-based form.

I do want to address a prior question about does the order count? I think it's somewhat important to put these in an intuitive order of what your process is.

So, here you'll notice that we put the asset in timely identification of who might be a progesterone candidate at the top. The next thing we put down there was trust, because you noticed when I started it started as an accusation. There was no trust and that was the whole different conversation.

We actually couldn't do anything without trust. And so, we put that there in an obvious way because there was no communication without trust.

And then you'll notice that the next piece is we can't do stuff to the patient without the patient. So, it was this partnership to actually help the patient that we wanted to call attention to. So, I do think there's an intuitive, almost chronologic patient journey to at least your key driver list.

The next one is outreach and involvement of unconventional partners. So, we had the county involved with the system change. So, there was absolutely no way the clinicians thought the county workers were at all connected to them doing a better job in the clinical adherence to progesterone. So that to them is a major lesson.

And then you see the insurance coverage which, of course, is contingent upon this partnership and communication with the counties.

And then the very last thing is, yes, we had issues around getting progesterone, which during this time switched from being compounded to needing name brand. So, it went from \$20 to \$800. But you'll notice that's the last thing on the list.

So, I do think there is an intuitive patient journey kind of order that's often helpful. Often at the bottom, you'll see things like the data, the IT infrastructure that actually helps.

So, in summary, in one page now you have an idea of what the take-home messages were, so that if you'd want to do this, these are the key things that would need to be covered.

Jim Jones: Right. And you too need to test these in your state.

Mary Applegate: Right.

Jim Jones: So, let's talk about slide 16. We're going through 16, 17, and 18. You can kind of walk us through slide 16 first. I think that'd be good. We're really interested in measures and the data that you're using to see how you're doing as you move through your process.

Mary Applegate: Yes. So, as it became clear that the system was important, we had to convey to the clinicians that it's important have a system realizing that we're transitioning from a fee-for-service climate to value-based purchasing.

So, first have a system, then get everyone in the system. That would be the expansion of Medicaid. And then after that, identify people at risk. And that's actually where the clinicians saw themselves. So showing them where they fit into this was really helpful.

And then after you find people at risk, do the stuff that you think you need to. So, on the clinical side, it was the provision of progesterone. On our side, it was paving the way with non-traditional health workers to outreach. To the African-American women, in particular, we use community health workers for example, and lots of communities.

The next was just to emphasize communications. And what you see here, we had what we called the "skinny form" because it wasn't the 72 ACOG items.

And essentially, this web-based form then notified the managed care plan, it notified the counties, it served as the prescription; it notified the preferred home health provider for the injections. And we're thinking in the future it could be used as a home visiting referral or a referral to other entities, regional centers of excellence, and something like that.

So, simplifying the right thing to do, we think is one of the most important things for sustainability. And then in that light, it shouldn't be last, but the building and maintaining trust is important as well. So, that's just the graphic of the simplification that I referenced in that prior one.

But when we did this work, what you'll see on slide 17, is we had some key measures that are not just the initiation of progesterone, which by the way, it's not the adherence to progesterone. We realized we had to pick some place and we did such a poor job just finding women and stating that we use initiation of progesterone as the strategy to reduce preterm birth.

So, what we had to measure was the universe of eligible women and then those that we were able to find between weeks 16 and 20. You really need to start it before 20 weeks. So, that there is a system issue related to eligibility there.

And then what we did is when we had these pregnancy risk assessment forms, we actually measured who was faxing them versus doing them online since we did all this work to simplify it.

And then we also measured the amounts of time it took to actually get progesterone. Because if someone comes in and it's week 16 and it takes you five weeks, you'd missed your chance.

So again, that was the result of talking to the clinicians about what the issues were. And you can see if you had to do all five or six of those steps in sequence by yourself as one practice or as the plan, you wouldn't get there.

And so, the simplification of communication meant that we're working in parallel. All of those things are happening at the same time. So, we should

be able to capture more women. We're losing about 15 percent of the women because it was too late even though we knew they were in our system.

And then this last one, the number of women who are actually losing coverage is how we measured that assistance at the county level.

So, on slide 18, what you'll see is the run chart with a lot of the efforts that I just described. And what you'll see is there's a significant change about a third of the way through it. And what I should note is the way that we know this is related to their counties.

Whenever we make a change, you don't see the change immediately in your run chart. It takes a while. It takes some time, typically, three months for whatever you change to actually hit the system. And so, that's exactly how we know that's connected to care management and not prior authorization, for example. The web-based communication did not change the line per se.

But, what might impact this is in January we started managed care on day one, so the women are not kind of in a free-for-all trying to navigate their own way which might be part of the percentage of women who's just playing show up too late.

Then we have the paper communication on slide 19. And you can actually see that fewer and fewer people are using paper over a period of time.

Jim Jones: So, as we look at slide 19, do you have any sort of words of wisdom, lessons learned, winning practices on quality improvement that you can share with the people who are in the webinar today?

Mary Applegate: Well, I think the main thing here was we recognize that in the processes, they were conveying the same information five times over. So, people are very comfortable with paper because that's what people are used to filling out for the last 20 years.

But once we said if you do it on the web-based tool, you only have to do it once. I think that's actually the most important piece. We simplified the work at every level as much as we could.

So, in some ways you could see that not only with the goal clear, but we paved the path. You know, to simplicity, essentially, for making the right thing, the easier thing to do. So, I think that was the most important piece of it. Essentially, the effort helped them get their daily work done.

Jim Jones: And as you look at the lessons learned on slide 20, could you talk a little about the rapid cycle that you went through for either of testing? You know, what was your duration? How did you come up with it?

Mary Applegate: So, it's interesting. People use this rapid cycle language and their data is three or six months old which makes it not actionable. So, we had weekly data related to the number of forms, we talked to the plans weekly or every other week, and then we had monthly calls with all of the participating sites together so that we could review data.

So, that's actually what the rapid cycle is. So, sometimes we tried things, and it didn't work, and then we abandoned it. If every time you do that, it's three months apart. You'll actually never get done. So, you'll notice the entirety of this effort took about 18 months. So, it wasn't three or four years, it was 18 months.

Jim Jones: That's remarkable that they do this much in 18 months and see the dramatic improvement that you've seen. It's incredible and commendable. Something that I think, all states could really learn from.

Let's just open up for questions and answers. I'd really like to open this up for all the attendees to ask questions of Dr. Applegate.

Katherine Griffith: Yes. Thank you, Jim and Dr. Applegate. This is Katherine again. We have some questions coming in, but please free to ask Dr. Applegate all the questions you have about how she went through this quality improvement process and developed the driver diagram.

So, the first one for Dr. Applegate, “how did you set your aim to percentages explicitly?”

Mary Applegate: So, I do think there is a little bit of smoke and mirrors in setting an aim. I think it’s based on existing data, what has been tried before with little to no success. And at least to subjective view of what their gaps are that you think you can do.

So, I think we started out with a fairly bold aim. Ten percent doesn’t sound like a lot, except if you multiply it by 70,000 deliveries, that’s 7,000 women you’re impacting. That’s actually kind of a lot.

So, we set it in a way that we thought we could actually achieve it. So, if your goal is “we’re going to do this for 100 percent of women,” well, I actually think, based on human behavior, that’s not a realistic thing.

So, I think we got the group to agree on how big of a step we could take in this amount of time given our common initial understanding of what the issues were. And so, you noticed we exceeded that because we were not thinking at the system’s level.

And I can give you an example too of how this happened over time. You wonder in the middle, “should we change the aim?” So, what happen is once we realized that the counties were really important, bwe had to explain to the doctors a little bit about eligibility, because they would come to the docs and say, “you know, the county won’t help me anymore.”

It was really more about food stamps or cash assistance or something that wasn’t the health benefit. And that’s part of why they were yelling at us that we’re dropping people left and right.

So, we had to describe to them actually how the process worked. And then when we look into it. The doctors were not allowed to be the people to call the county for official notification of pregnancy. It had to be the patient themselves or the managed care plan.

So, initially, when we educated the providers, they couldn't actually move that piece. The counties certainly could, but then we also had the county pregnancy-related services coordinator help as well.

So, then we also had a dedicated mailbox for 88 counties. So, we couldn't do 88; so we tried in the three largest counties. And then realized doing it 88 times and making sure that no one's on vacation to babysit the mailbox that's how we got to that web-based application that then is tied to eligibility.

So, that might be an example of the rapid cycle PDSAs that we did. But the entire time, even though we realized we could do this, we did not change our original goal. We just ended up exceeding it because of what we learned as we went.

Katherine Griffith: Great, thank you. So, we know that you started out with the more clinical driver diagram and then got into the process and moved to a more system-level. But, can you talk a little bit about how you brought the providers, the clinicians along in the revisions of the driver diagram? Did they have to buy-in on how it was revised?

Mary Applegate: Yes. So, yes, the document is owned by the group. So, even though we had a separate parallel process within the managed care plans, we met with all of the clinical and managed care plan entities together at least on a quarterly basis and then also had monthly calls. So I think when they saw that we listened and then essentially did what they said, removed prior authorization, for example, that was a game changer actually.

Because now there's that trust that let the entire group actually weigh in on how they think it needs to be. And it's actually a way that we grounded the meetings.

We would start with the old and then the new key driver diagram at that point in time and ask for revisions. And then after those meetings we would send out the newest key driver diagram with that new date.

So, it really morphed over time but everybody owned it. So, I'm hoping that they're all having conversations with the same key driver diagrams with different groups of people.

Katherine Griffith: Great.

Mary Applegate: So, I think this was part of the trust piece. So, I wouldn't say necessarily that it's a given on the front-end.

Katherine Griffith: Yes. That's great. And just for others on the webinar, when you're thinking about how to apply this within your state, it sounds like Dr. Applegate has gone through a lot of these steps and challenges, so you're thinking about what to ask. I think you want to think about how you can apply it in your state, in your delivery system reforms.

So, the next question is how did you determine the measures that you reviewed on a previous slide? Not just the aim measure, but all of those measures?

Mary Applegate: Yes. That's a great question. And that's a little bit tricky because in the discussions, just like I told you at the beginning, if you're not sure what to put on your key driver, just ask what frustrates you. The way to get those process measures is to ask, "well, what do you really need to know to see if that step is working for you?"

And so there would be these requests. So, "can you tell us the variation and how long it takes different plans to respond to the progesterone request?"

And actually, the clinicians had no idea how complicated the managed care plans processes are. So, an insurer has at least the complexity of an entire health system because many of the plans are national, for example. And so, it's not as simple as we'll write and edit and put it in there.

So, there was a little bit of understanding of what it took. And especially, as we were able to collect that data and actually show it to them, they realized that the plans were improving as well and that also then became part of the trust building.

So, it was based on the request of the group what would be helpful to know as a more approximate measure because we don't want to wait 20 weeks to make sure that we've captured all of the women getting progesterone.

So, it was part of the conversation. And then what we had to do is land on a smaller one. Once you have too much granular information, you don't know where to focus.

So, that's actually why the key driver diagram is so important. It only measures the things that are directly connected with an arrow from one box to the next to the ones on the far left-hand side. And then generally, we don't have more than three kinds of process measures at a time because you can't pay attention to that much at the same time.

Katherine Griffith: Great. Thank you. So, another question. I think, this is a big one because we want to think about how you can apply these quality improvement tools in all types of delivery system reforms, whether it's developing FCMH which we believe Ohio had.

So, the question is "how have you in Ohio Medicaid used driver diagrams and other types of delivery system reform programs?"

Mary Applegate: Well, you'll be interested to know that here whenever we're doing a Medicaid agency sponsored anything, we actually ask for the key driver diagram as part of the submission of the effort. Because we want to know not just what you're going to do but how it is it going to help.

So, it forces people to actually crystallize and make sure that there is a theory and some logic and possibly evidence from actually what you're doing and what measure you're trying to move. So, that sounds perhaps elementary, but that actually is a thing.

So, sometimes the intervention is not really connected to the measure that you're trying to do or you have no way to know. So, for example, in the opioid space, you don't just want to measure people who died, right? That's like way too late. You've got to measure other things before that.

So, what we ended up doing is for any request, the key driver diagram comes with it. But we specifically put in our managed care contract requirements around QI expertise.

And then the other thing that we did is we ask our federal partners, as part of the required performance improvement projects that we have to do, if we could do it this way using these kinds of tools instead of the old way, which is identify a problem, put in a program, and measure before and after.

And there's actually a leverage there because of the plan credit for doing those. The other good thing about that is we have all the plans working on the same thing at the same time. And then that's actually how you get scale and population level health improvement.

So, to us, this is a new way of working with our managed care plans. They actually can be an engine to helping solve some of these health issues one by one because whatever the intervention is you can take it to scale through them using the tools.

Katherine Griffith: And just so everybody knows, I didn't pay Dr. Applegate to say that. It's a requirement now for everybody in the State of Ohio to do it.

Mary Applegate: The requirement is the choice we made, yes.

Katherine Griffith: Yes. So, I think that's great. And that it's good to encourage your partners to set those goals ahead of time, right. We are asking states to think about upfront also.

I think that is actually all the questions that we have for today. Unless there's any last-minute questions that come in. I think, that is it.

So, Dr. Applegate, thank you. And I'll turn it over Jim to close out the webinar.

Jim Jones: Yes, thank you. And thank you, Dr. Applegate, for all that really valuable information.

I think, like Katherine, I love the fact that the key driver diagram is something that's required and you have to have evidence to show a measure you're actually trying to move.

So, if you're a participant on this webinar, you may be asking yourself, "when I go back to my work group, what can I take away from the webinar? What are some questions we can ask that really start moving us in some of the directions of the quality improvement suggestions?"

So, the first one, and I think Dr. Applegate said it, ask people what frustrates them. Ask the question, "what is the problem you're trying to solve? What are you trying to do in your Medicaid program? What problem do you have that you're trying to solve?"

And then as we mentioned when we're talking about aims, what's the exact target population of these improvements? Is it people who are 65 years of age and older? Is it people with physical disabilities? Is it children? Is it pregnant women like in Ohio and Dr. Applegate's example? Really knowing who that target population is in a specific place. All of those things really help you hone in on what you actually need to do.

And then the next question that we ask people about is what do you actually want to report within that time period? Let's say, two years from now, to your Medicaid director, or to your secretary, or your governor. What do you actually want to tell them, what's the story you want to tell two years from now on your project?

We were successful. We did this. This is what we actually accomplished. We moved the dial on this particular measure and this many people are better

off. Seven thousand pregnant women. There's a lot of pregnant women and we know that in Ohio they probably found the change and the goal even in a much higher number than that.

So, the last question we ask that you look at is how do you know if you are successful or not? Really, this comes down to do you really want data-driven decision-making? So, what data do you have or will you need that you're going to look at to see how you're moving forward?

And it's not just the data associated with your aim, it's also the data that helps you measure how you're going for two or three of those secondary or primary drivers to give you a sense if you're making progress through the project. Even though you haven't gotten to the point where you might be affecting the target population the way that you wanted to, that's described in the aim statement.

So, we're asking you so to take this idea back, talk to your work groups, because we know you're all in work groups, and then you're meeting all the time, and just trying talk to your team about these particular questions and the ideas that we have here, and then maybe we'll start a discussion for you.

Maybe it's a new perspective that you need in your work group to solve the problem that you've been trying to get out and try to make the kind of progress that your boss is all looking for and the public is looking for.

So, let's talk about the next step in this process. We're going to have another webinar in September for part two. You'll learn more about how QI can be used in delivery system reform, what kind of work might we want to use for the quality improvement tools, how we can start measuring, and what isn't a measurement that you'd probably want to do.

During part two, you can expect to learn from other states' experiences, just as what we learned today from Ohio about using those QI tools and methods. You'll learn how to use the driver diagram to develop that iterative testing cycle, that Plan-Do-Study-Act plan as we talk about testing those hypotheses and testing your strategies.

And then finally, we'll discuss opportunities to use QI in the work that you're already doing and I think that's going to be a great webinar that we're planning on having. And look for an e-mail soon that tells you the exact dates and sets up an appointment for you to attend.

So, I want to thank everybody for joining today. It's really important that we hear from you to make sure that we're providing you with information you find valuable. That this is good use of your time and that this is moving the needle and the quality improvement path.

So, we're going to send out a survey and we're asking you to complete the survey at the conclusion of the event. If you have any questions that you'd like to ask as they pop-up, we're here to help you support that learning experience. So, give us a shout, send us an e-mail and we'll help you answer those questions.

And if you have any ideas for additional QI learning opportunities, I would love to hear about those as well on different way of doing it, subjects that you'd like us to go into, any of those kinds of things I would love to hear from you.

And we hope that you enjoyed this time with us on this webinar on quality improvement in Medicaid delivery system reform. So, you all have a very, very nice day and good-bye.

Mary Applegate: Thank you.

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

END