State of Georgia
Department of Community Health
Georgia Families Program

# CY 2016 Performance Improvement Projects Report

*for*

# Amerigroup Community Care

*Reported June 2017*

HSAG HEALTH SERVICES ADVISORY GROUP

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## Acknowledgements and Copyrights

# 1. Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service (FFS) and managed care components and deliver services through a statewide provider network. The FFS program has been in place since the inception of Medicaid in Georgia. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to certain categories of members enrolled in the State's Medicaid and PeachCare for Kids® programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families 360° (GF 360°) managed care program. The Georgia Families (GF) program, implemented in 2006, serves all other Medicaid and PeachCare for Kids® managed care members not enrolled in the GF 360° program.

The DCH requires its contracted CMOs to conduct performance improvement projects (PIPs). As set forth in 42 CFR §438.240, the PIPs must be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and nonclinical care areas. The PIPs are expected to have a favorable effect on health outcomes and member satisfaction. The DCH requires the CMOs to report the status and results of each PIP annually. Amerigroup Community Care (Amerigroup) is one of the Georgia Families CMOs.

The validation of PIPs is one of three federally mandated activities for state Medicaid managed care programs. The evaluation of a CMO's compliance with State and federal regulations and the validation of a CMO's performance measure rates are the other two mandated activities.

These three mandatory activities work together to assess a CMO's performance with providing appropriate access to high-quality care for their members. While a CMO's compliance with managed care regulations provides the organizational foundation for the delivery of quality healthcare, the calculation and reporting of performance measure rates provide a barometer of the quality and effectiveness of the care. The DCH requires each CMO to initiate PIPs to improve the quality of healthcare in targeted areas of low performance, or in areas identified as State priorities or healthcare issues of greatest concern. During calendar year (CY) 2016, DCH required its CMOs to conduct two clinical and two nonclinical PIPs and submit the final PIP modules for annual validation in 2017. PIPs are key tools in helping DCH achieve goals and objectives outlined in its quality strategy; they provide the framework for monitoring, measuring, and improving the delivery of healthcare.

The purpose of a PIP is to assess and improve processes, and thereby outcomes of care. For such projects to achieve real and meaningful improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. The primary objective of PIP validation is to determine each CMO's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities to increase or sustain improvement.

To meet the federal requirement for the validation of PIPs, DCH contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to conduct the validation of Amerigroup's PIPs.

In response to feedback and input from DCH, HSAG developed the rapid-cycle PIP framework in 2014 based on a modified version of the Model for Improvement developed by Associates in Process Improvement[1-1] and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-2] The rapid-cycle PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement. For CY 2016, the CMOs in Georgia continued to use HSAG's rapid-cycle PIP process. The DCH instructed the CMOs to conduct their rapid-cycle improvement projects over a 12-month period.

To support the efforts of DCH and the CMOs, HSAG provided various forms of guidance for the rapid-cycle improvement projects including:

- A detailed Companion Guide describing the rapid-cycle PIP framework and the requirements for each module submission.
- Forms for the CMOs to document their progress through the different stages of the new PIP process for each of the five modules.
- Corresponding validation feedback forms for communicating validation findings on each module back to the CMOs and DCH.
- A presentation and interactive critical-thinking activity related to developing innovative and fundamental changes for performance improvement during the Georgia Families 2016 CMO Conference.
- Extensive technical assistance via conference calls with the CMOs and DCH throughout the 12-month project period.

To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects*

[1-1] Associates in Process Improvement. Model for Improvement. Available at: http://www.apiweb.org/ Accessed on: May 10, 2017.
[1-2] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Sept 24, 2015.

*(PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-3] In 2014, HSAG provided CMS with a crosswalk of the rapid-cycle PIP framework to the CMS PIP protocols in order to illustrate how the rapid-cycle PIP framework met the CMS requirements.[1-4] Following HSAG's presentation of the crosswalk and new PIP framework components to CMS, CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable. CMS approved HSAG's rapid-cycle PIP framework for validation of the Georgia Families and Georgia Families 360° CMOs' PIPs.

HSAG's validation of rapid-cycle PIPs includes the following key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aim, key driver diagram, and SMART Aim data collection methodology) was based on sound methods and could demonstrate reliably positive outcomes. Successful execution of this component ensures accurately reported PIP results that are capable of measuring sustained improvement.
2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation using iterative PDSA cycles, and sustainability and spreading of successful change. This component evaluates how well the CMO executed its quality improvement activities and whether the desired aim was achieved.

The goal of HSAG's PIP validation is to ensure that DCH and key stakeholders can have confidence that any reported improvement in outcomes is related and can be directly linked to the quality improvement strategies and activities conducted by the CMO during the life of the PIP.

## PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions, testing interventions, and planning for the spread of successful changes. The core component of the rapid-cycle approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The following outlines the rapid-cycle PIP framework.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.
[1-4] Ibid.

- Module 1—PIP Initiation: Module 1 outlines the framework for the project. The framework follows the Associates in Process Improvement's (API's) Model, which was popularized by the Institute for Healthcare Improvement, by:
  - Precisely stating a project-specific SMART Aim (specific, measureable, attainable, relevant and time-bound) including the topic rationale and supporting data so that alignment with larger initiatives and feasibility are clear.
  - Building a PIP team consisting of internal and external stakeholders.
  - Completing a key driver diagram which summarizes the changes that are agreed upon by the team as having sufficient evidence to lead to improvement.
- Module 2—SMART Aim Data Collection: In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed in run charts.
- Module 3—Intervention Determination: In Module 3, there is a deeper dive into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions, in addition to those in the original key driver diagram, are identified for PDSA cycles (Module 4) using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking.
- Module 4—Plan-Do-Study-Act: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- Module 5—PIP Conclusions: Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, plans for evaluating sustained improvement and expansion of successful interventions, and lessons learned.

## Summary of Amerigroup's Performance

For CY 2016, Amerigroup submitted four PIPs for validation. The PIPs were validated using HSAG's rapid-cycle PIP validation process. The PIP topics included:

- *Bright Futures*
- *Member Satisfaction*
- *Postpartum Care*
- *Provider Satisfaction*

Amerigroup followed the PIP methodology as identified in the rapid-cycle PIP Companion Guide provided by HSAG. For each PIP conducted in CY 2016, Amerigroup defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation. HSAG provided the following parameters to Amerigroup for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Table 1-1 outlines the PIP topics and final CMO-reported SMART Aim statements for the four PIPs. The CMO was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. Amerigroup developed a SMART Aim statement that quantified the improvement sought for each PIP.

**Table 1-1—PIP Titles and SMART Aim Statements**

| PIP Title | SMART Aim Statement |
|---|---|
| *Bright Futures* | By December 31, 2016, increase the rate of developmental screenings for 9-month-old members in Chatham County from 63.3% to 73.3%. |
| *Member Satisfaction* | By December 31, 2016, increase the rate of "Always" responses to question 18 "In the last six months, how often did your child's personal doctor listen carefully to you?" for members serviced at Toccoa Clinic from 76.0% to 90.0%. |
| *Postpartum Care* | By December 31, 2016, increase the rate of postpartum visits between 21–56 days after a live birth from 76.5% to 86.5% for The Longstreet Clinic. |
| *Provider Satisfaction* | By December 31, 2016, increase the rate of provider satisfaction among providers who were invited to orientation from 24.0% to 60.0%. |

## Validation Overview

HSAG obtained the data needed to conduct the PIP validation from Amerigroup's module submission forms. These forms provided detailed information about each of Amerigroup's PIPs and the activities completed in Modules 1 through 5.

Amerigroup submitted Modules 1 through 3 for each PIP in CY 2016 for validation. The CMO initially submitted Modules 1 and 2, received feedback and technical assistance from HSAG, and resubmitted these modules until all validation criteria were met. Amerigroup followed the same process for Module 3. Once Module 3 was approved, the CMO initiated intervention testing in Module 4, which continued through the end of 2016.

HSAG offered Amerigroup the opportunity to submit a Module 4 plan for each PIP for pre-validation review and feedback to ensure a sound testing methodology for the Module 4 PDSA cycles. The Module 4 plan consists of a description of the intervention being tested, a narrative justification describing why the CMO selected the intervention for testing, the CMO's plan for carrying out the intervention, and the intervention evaluation plan, including data collection methodology. The CMO chose to submit Module 4 documentation for pre-validation for two PIPs, *Member Satisfaction* and *Postpartum Care*. HSAG provided detailed, written feedback on the Module 4 plans for these PIPs and additional technical assistance by teleconference, as needed. Amerigroup submitted the final Modules 4 and 5 to HSAG on January 31, 2017, for annual validation.

The scoring methodology evaluates whether the CMO executed methodologically sound improvement projects, whether each PIP's SMART Aim goal was achieved, and whether improvement was clearly linked to the quality improvement processes applied in each project. HSAG assigned a score of *Achieved* or *Failed* for each of the criteria in Modules 1 through 5. Any validation criteria that were not applicable were not scored. HSAG used the findings for the Modules 1 through 5 criteria for each PIP to determine a confidence level representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- *Confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- *Low confidence* = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- *Reported PIP results were not credible* = The PIP methodology was not executed as approved.

## Validation Findings

HSAG organized and analyzed Amerigroup's PIP data to draw conclusions about the CMO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goals. The validation findings for Amerigroup's PIPs are presented in Table 2-1 through Table 2-8. The tables display HSAG's key validation findings for each of the PIPs including the interventions tested, the key drivers and failure modes addressed by the interventions, and the impact of the interventions on the desired SMART Aim goals.

For each PIP, HSAG evaluated the appropriateness and validity of the intervention-testing measure(s), SMART Aim measure, and data collection methods, and assessed the reported SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved.

### *Bright Futures*

Amerigroup's goal for the *Bright Futures* PIP was to identify and test interventions to improve the rate of members in Chatham County who received a nine-month developmental screening. Because the SMART Aim goal was exceeded and the quality improvement processes were clearly linked to the demonstrated improvement, the PIP was assigned a level of *High Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 2-1 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

**Table 2-1—SMART Aim Measure Results for *Bright Futures***

| SMART Aim Measure | Baseline Rate | SMART Aim Goal Rate | Highest Rate Achieved | Confidence Level |
|---|---|---|---|---|
| The percentage of members in Chatham County that received a 9-month developmental screening | 63.3% | 73.3% | 87.5% | *High Confidence* |

The CMO established a goal of improving the nine-month developmental screening rate for members in Chatham County by 10 percentage points, from 63.3 percent to 73.3 percent. The SMART Aim measure rate exceeded the goal rate of 73.3 percent for five consecutive months following initiation of the

intervention. The details of the improvement processes used and the intervention tested are presented in Table 2-2 and in the subsequent narrative description.

**Table 2-2—Intervention Testing for *Bright Futures***

| Intervention | Key Drivers Addressed | Failure Mode Addressed | Conclusions |
|---|---|---|---|
| Monthly fax communication with primary care providers in Chatham County to provide education on eligible members assigned to the provider who were due for a nine-month developmental screening | • Primary Driver: Provider compliance<br>• Secondary Driver: Provider education and engagement | Provider realizes too late that the member has not scheduled an appointment by the recommended age and therefore misses the opportunity for a preventive visit | Based on success in achieving the SMART Aim goal and lessons learned during the PIP from participating providers, the intervention will be adapted and testing will continue. |

Amerigroup tested one intervention for the PIP: faxing lists of members due for a nine-month developmental screening to primary care providers in Chatham County. To carry out this intervention, the CMO identified eligible members by age, residence, and PCP. The CMO sent monthly fax communications to PCPs in Chatham County that included a list of members who would be due for a nine-month developmental screening in the next month. The purpose of the monthly fax communications was to enable providers to easily identify members due for the service and engage providers in scheduling and completing the developmental screening during the recommended time frame.

The CMO used the SMART Aim measure (percentage of members in Chatham County who were due for a nine-month developmental screening and received a screening) to test the intervention and also collected process data on the provider response rate to the faxed member lists. The SMART Aim measure was appropriate to evaluate intervention effectiveness because the intervention included all members eligible for the measure. The CMO used the provider response rate to examine the administrative burden of the intervention on providers and to determine reasons members did not receive the nine-month screening. The CMO tested the intervention for six months, from June through November, and the SMART Aim goal of 73.3 percent was exceeded for five consecutive months from July through November. The CMO concluded that the intervention was successful; however, it determined that the intervention needed to be adapted to address the administrative burden and increase buy-in from participating providers, as a next step.

While the CMO concluded that the intervention was effective, based on the intervention testing and SMART Aim measure results, it acknowledged that many lessons were learned, suggesting the intervention could be further improved. The CMO documented the following lessons learned:

- Qualitative feedback from participating providers suggested that the manual data collection process required for the PIP may have reduced the provider response rate.
- Using the electronic health record (EHR) as a means for communicating with members due for the nine-month developmental screening may be more convenient for providers than the manual process used during the PIP.
- Automating communication between the CMO and providers regarding members due for the nine-month developmental screening is likely to benefit providers, members, and the CMO by reducing the burden of data collection and allowing providers to focus more time on caring for members.

Based on a thorough review and evaluation of Amerigroup's *Bright Futures* PIP documentation, HSAG determined *High Confidence* in the PIP results. Amerigroup demonstrated that the selected intervention, monthly fax communication with providers, was effective in improving the nine-month developmental screening rate in the targeted county. Although the intervention facilitated achievement of the SMART Aim goal, the CMO identified aspects of the intervention that could be refined to support sustained and expanded improvement of the nine-month developmental screening rate. Amerigroup provided a sound rationale for adapting the intervention and testing it further. Based on the documented lessons learned, a logical next step would be to adapt the intervention to allow more efficient communication between the CMO and PCPs and reduce administrative burden for carrying out the intervention. By reducing administrative burden on providers, the CMO will increase the sustainability of improvement.

HSAG recommends that Amerigroup build on the success of the PIP by refining the improvement strategy using lessons learned and test the adapted intervention through further PDSA cycles. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results. Additionally, the CMO should make efforts to gradually expand the intervention to a wider group of providers if future testing results continue to demonstrate the effectiveness of the intervention, with the ultimate goal of spreading an effective intervention statewide.

## *Member Satisfaction*

Amerigroup's goal for the *Member Satisfaction* PIP was to identify and test interventions to improve member satisfaction by improving communication between members and providers. Because the SMART Aim goal was exceeded and the quality improvement processes were clearly linked to the demonstrated improvement, the PIP was assigned a level of *High Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 2-3 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

**Table 2-3—SMART Aim Measure Results for *Member Satisfaction***

| SMART Aim Measure | Baseline Rate | SMART Aim Goal Rate | Highest Rate Achieved | Confidence Level |
|---|---|---|---|---|
| The percentage of members serviced at Toccoa Clinic who answered question 18, "In the last six months, how often did your child's personal doctor listen carefully to you?" with the response, "Always" | 76.0% | 90.0% | 100.0% | *High Confidence* |

The CMO established a goal of increasing the percentage of members who received care at Toccoa Clinic and answered "Always" to the survey question, "In the last six months, how often did your child's personal doctor listen carefully to you?" by 14 percentage points, from 76.0 percent to 90.0 percent. The SMART Aim measure met or exceeded the goal of 90.0 percent for five of six monthly measurements following the intervention. The details of the improvement processes used and the intervention tested are presented in Table 2-4 and in the subsequent narrative description.

**Table 2-4—Intervention Testing for *Member Satisfaction***

| Intervention | Key Driver Addressed | Failure Modes Addressed | Conclusions |
|---|---|---|---|
| Training providers at the targeted clinic on the teach-back method for improving communication between providers and members | Members do not understand the explanation or direction given to them by their providers | • Doctor does not read back the question to validate he or she understands the member's question<br>• Doctor does not consider this member might not understand the treatment plan, so the doctor moves on to the next visit | Based on the summary of findings, the CMO determined the intervention was successful. The CMO chose to adapt the intervention to incorporate lessons learned and address additional components of provider-member communication that can impact member satisfaction. |

Amerigroup tested one intervention for the PIP: training providers at the targeted clinic on the teach-back method for improving interactions between providers and members. The teach-back method is a communication strategy that can be taught to providers to ensure they are listening to their patients and are communicating health information in a way that is easy to understand and remember. To initiate the intervention, the CMO partnered with Merck & Co., Inc., to present a teach-back technique training

class to providers at the targeted clinic. Thirty-three providers from the targeted clinic attended the training, which included a presentation, role playing, and open discussion. The providers were informed during the training of the expectation that the teach-back method be used during office visits with members.

To test the intervention, the CMO tracked an intervention-specific measure focused on those providers who received the training and those members who experienced the teach-back method during a visit with one of the trained providers. Phone survey data from these members regarding their satisfaction with provider listening were collected and measured monthly. The intervention-specific measure was separate from the SMART Aim measure, but the same goal of 90.0 percent was set for both measures. The intervention-specific measure of effectiveness met or exceeded the goal of 90.0 percent for four of six monthly measurements after the intervention occurred, and all measurements following the intervention exceeded the baseline rate. The SMART Aim measure met or exceeded the goal of 90.0 percent for five of six monthly measurements following the intervention. Based on the monthly performance on the intervention-specific measure of effectiveness and the overall SMART Aim measure performance, the CMO concluded that the intervention was effective.

The CMO provided a sound rationale for adapting the intervention to incorporate some of the lessons learned and address additional components of provider-member communication that can impact member satisfaction, such as demonstrating respect and providing easy-to-understand explanations. The CMO reported the following lessons learned:

- Listening is only one component of effective communication. Additional components include demonstrating respect for the member and providing easy-to-understand explanations during the appointment.
- Other factors impacting member satisfaction at the provider level include the patient-to-provider ratio for a clinic and changes in the leadership of the clinic.
- The inability to reach members by phone to complete the satisfaction survey continued to be a barrier; however, the survey response rate for the PIP (22 percent) was similar to historic response rates for the CAHPS phone survey.

HSAG conducted an in-depth review and evaluation of Amerigroup's *Member Satisfaction* PIP documentation and determined *High Confidence* in the PIP results. Amerigroup demonstrated that the tested intervention, training providers on the teach-back method of communication, was effective in improving member satisfaction with provider communication during appointments at the targeted clinic. The intervention supported achievement of the SMART Aim goal; however, the CMO identified additional areas of member-provider interactions that could be addressed to support sustained and expanded improvement of member satisfaction. HSAG supports the CMO's plans for ongoing monitoring of member satisfaction with the providers who attended the teach-back method training. Through ongoing monitoring of member satisfaction with the providers who participated in the intervention, the CMO will be able to assess the long-term sustainability of the improvement demonstrated in the PIP.

Given the success of the PIP, HSAG recommends that the CMO also consider expanding the teach-back training intervention beyond the initial scope of the PIP. The CMO should view the successful PIP results as a step in the process of improving satisfaction on a larger scale, well beyond the initial, narrowed focus of the PIP. The CMO should use PDSA cycles to gradually ramp up participation in the teach-back training among providers at additional provider practices and other facilities. With the use of ongoing PDSA cycles, the CMO can continue to refine the intervention and adapt it, as necessary, for other specialties or types of facilities. The gradual expansion and refinement of the intervention will support improved satisfaction with provider communication among members statewide.

## *Postpartum Care*

Amerigroup's goal for the *Postpartum Care* PIP was to identify and test interventions to improve the postpartum visit rate among members who delivered a live birth and received care from a provider at The Longstreet Clinic. Because the SMART Aim goal was not achieved, the PIP was assigned a level of *Low Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 2-5 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

**Table 2-5—SMART Aim Measure Results for *Postpartum Care***

| SMART Aim Measure | Baseline Rate | SMART Aim Goal Rate | Highest Rate Achieved | Confidence Level |
|---|---|---|---|---|
| The percentage of members who received care from The Longstreet Clinic, delivered a live birth, and completed a postpartum follow-up visit within 21–56 days of the birth | 76.5% | 86.5% | 79.0% | *Low Confidence* |

The CMO established a goal of improving the percentage of women who received care at The Longstreet Clinic and completed a postpartum visit within 21–56 days of delivering a live birth by 10 percentage points, from 76.5 percent to 86.5 percent. None of the monthly SMART Aim measurements met the goal of 86.5 percent. The details of the improvement processes used and the intervention tested are presented in Table 2-6 and in the subsequent narrative description.

**Table 2-6—Intervention Testing for *Postpartum Care***

| Intervention | Key Driver Addressed | Failure Modes Addressed | Conclusions |
|---|---|---|---|
| Live outreach calls conducted by the targeted provider to members who delivered a live birth and were due for a postpartum visit | Member engagement | • Member has not scheduled appointment for postpartum visit at time of discharge<br>• Member does not receive education on scheduling a postpartum visit prior to visit due date<br>• Member has Cesarean section incision check but does not schedule a separate postpartum visit | Based on the intervention testing results, the CMO chose to adapt the intervention and conduct further testing. |

Amerigroup tested one intervention for the PIP, telephone outreach conducted by the participating clinic, to members who delivered a live birth, to promote and schedule the postpartum visit. To initiate outreach activities, the CMO provided lists of members to the participating clinic, based on hospital billing data for deliveries. The clinic staff conducted live outreach phone calls to members within 21 days of the delivery date. During the outreach call, the clinic staff offered the member education on the postpartum visit and assisted in scheduling the visit within 21–56 days following the birth.

To test the intervention, the CMO collected process data on the clinic's outreach call volume and tracked the percentage of eligible members outreached who completed a timely postpartum visit. The monthly data were plotted on a run chart. The test results showed that the clinic's outreach call volume increased after the intervention was initiated and the postpartum visit rate was higher among those who received the telephone outreach intervention; however, the intervention was not sufficient to achieve the SMART Aim goal for all eligible members included in the PIP.

Based on lessons learned from the PIP, the CMO plans to incorporate one of the following adaptations and conduct further testing of the intervention: add a follow-up letter to the member, use the provider's electronic medical record (EMR) platform to conduct automated member follow-up, or partner with the provider to promote the CMO's member incentive for completing a timely postpartum visit.

The CMO documented the following lessons learned:

- More frequent team meetings improved consensus building and the capacity for rapid-cycle analysis, and ensured use of a valid data collection methodology.

- Improving phone outreach did not address all of the barriers to completing a timely postpartum visit. Newly identified barriers included limitations of delivery billing data in linking the member with the appropriate provider and appointment "no shows."
- Provider billing data may be a more effective data source than the CMO's inpatient census data for identifying members eligible for the outreach intervention.

After an in-depth review and assessment of Amerigroup's *Postpartum Care* PIP documentation, HSAG determined *Low Confidence* in the PIP results. The PIP did not demonstrate real improvement because the SMART Aim goal was not achieved during the life of the PIP. The CMO tested one intervention, member outreach calls by the targeted provider, and this intervention alone was not sufficient to achieve a postpartum visit rate of 86.5 percent among all eligible members receiving care at the selected clinic. The PIP results suggest that the telephone outreach intervention did not address all of the barriers to completing a timely postpartum visit and the CMO needed to pursue additional interventions, beyond telephone outreach, to meet the goal.

The CMO should explore other interventions to increase member engagement in scheduling and attending the postpartum appointment. The impact of the telephone outreach intervention was limited to those members who were able to be reached. Additionally, the intervention primarily focused on scheduling the postpartum visit and did not address barriers to attending the postpartum appointment once it is scheduled. The CMO should follow up with members who had a visit scheduled but did not attend, to identify specific barriers, such as childcare, transportation, scheduling issues, or forgetting the scheduled appointment. HSAG recommends that the CMO convene the PIP team members and other key stakeholders and revisit the key driver diagram, process map, and FMEA, revising these quality improvement tools and analyses based on lessons learned from the PIP. The CMO should build on the PIP results to develop additional improvement strategies to test, continuing the rapid-cycle process until the desired improvement has been achieved.

## Provider Satisfaction

Amerigroup's goal for the *Provider Satisfaction* PIP was to identify and test interventions to improve provider satisfaction with the CMO's provider orientation process and resources. The SMART Aim goal was achieved, and some but not all of the quality improvement processes were clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 2-7 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

**Table 2-7—SMART Aim Measure Results for *Provider Satisfaction***

| SMART Aim Measure | Baseline Rate | SMART Aim Goal Rate | Highest Rate Achieved | Confidence Level |
|---|---|---|---|---|
| The percentage of providers invited to provider orientation who reported being satisfied with the orientation | 24.0% | 60.0% | 67.0% | *Confidence* |

The CMO established a goal of increasing the percentage of providers who reported being satisfied with provider orientation by 36.0 percentage points, from 24.0 percent to 60.0 percent. The SMART Aim measure rate exceeded the goal rate of 60.0 percent for two of the PIP's monthly measurements. Three additional monthly measurements (40.0 percent, 50.0 percent, and 50.0 percent, respectively) were more than 15 percentage points above the baseline rate but did not achieve the goal rate. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 2-8 and in the narrative description below.

**Table 2-8—Intervention Testing for *Provider Satisfaction***

| Intervention | Key Driver Addressed | Failure Mode Addressed | Conclusions |
|---|---|---|---|
| Live telephone outreach to providers to promote registration for provider orientation and enhanced online provider orientation materials and resources | Provider awareness | The orientation ends but outstanding provider questions remain | Based on the intervention testing results, the CMO determined that the intervention was too resource-intensive and chose to adapt it for further testing. |

Amerigroup tested one intervention for the PIP: live telephone outreach to promote registration for provider orientation and increase awareness of enhanced online provider orientation materials. To carry out the intervention, the CMO's Provider Solutions staff placed follow-up outreach calls to new providers who had received an invitation to attend an in-person provider orientation session. During the outreach call, providers were encouraged to register for and attend an orientation session. The phone calls directed the providers to the updated provider training website, where providers can register for an orientation session and access provider resources. The providers were educated on the web-based resources which included tools, webinars, forms, and tutorials for providers.

The CMO tested the intervention by linking process data on successful outreach calls and provider orientation registration to results of a follow-up telephone survey which gauged satisfaction with the CMO's provider orientation process. Following initiation of the intervention, the CMO reported an

increase in registration rates for provider orientation. Concurrently, the SMART Aim measure remained above the baseline rate of 24.0 percent for seven consecutive months, and the SMART Aim goal (60.0 percent for the percentage of providers who reported being satisfied with the orientation) was met for two monthly SMART Aim measurements. The CMO determined that the intervention was successful and provided a sound rationale for adapting the intervention, based on lessons learned, and conducting further testing with additional providers.

The CMO documented the following lessons learned:

- Individual live outreach to providers improved satisfaction with the provider orientation; however, the outreach was resource-intensive and inefficient.
- A satisfaction survey follow-up question with four levels of responses (i.e., always, usually, sometimes, never) would have provided more meaningful data than the yes/no question that was used for the project.
- Providing other survey modes, such as email or text message, in addition to a phone survey may improve the survey response rate.

HSAG determined *Confidence* in the PIP results, based on a detailed review and evaluation of Amerigroup's *Provider Satisfaction* PIP documentation. The SMART Aim goal was achieved, and some but not all of the quality improvement processes were clearly linked to the demonstrated improvement. The CMO's documented summary of findings for intervention testing in Module 4, and overall PIP results in Module 5, contained minor errors. The primary error in the CMO's summary of findings was the omission of December data for the intervention testing run charts in Module 4 and the SMART Aim run chart in Module 5. While the omission of December data did not prevent the CMO from demonstrating improvement in the SMART Aim measure and linking the demonstrated improvement to the intervention for the months of May through November, the missing data for December prevented the CMO from linking the SMART Aim measure results to the intervention for the last month of the PIP.

To build on the PIP results and lessons learned, HSAG recommends that Amerigroup continue to use PDSA cycles to test the adapted intervention, such as web-based or text-based modes of provider outreach and education, to further improve satisfaction with the provider orientation process and resources. In future PIPs, the CMO should ensure that the SMART Aim run chart results are reported for the entire life of the PIP. Additionally, the CMO should institute an internal review and validation process for the written PIP documentation to ensure results are reported consistently and accurately, without errors or omissions.

# 3. Conclusions and Recommendations

## Conclusions

A summary table of Amerigroup's performance across all four PIPs, including reported SMART Aim measure rates and the level of confidence HSAG assigned for each PIP, is provided in Appendix A. HSAG assigned the level of *High Confidence* for two of Amerigroup's PIPs, *Bright Futures* and *Member Satisfaction*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the quality improvement processes were clearly linked to the demonstrated improvement. HSAG assigned the level of *Confidence* for the *Provider Satisfaction* PIP because the SMART Aim goal was achieved; however, some but not all of the CMO's quality improvement processes could be linked to the demonstrated improvement. Finally, HSAG assigned the level of *Low Confidence* for the *Postpartum Care* PIP because the SMART Aim goal was not achieved during the life of the PIP.

Amerigroup's performance across the four PIPs suggests that the CMO has made progress in successfully executing the rapid-cycle PIP process. This progress is demonstrated by HSAG assigning two of the four CY 2016 PIPs the level of *High Confidence* and one other PIP the level of *Confidence*. In each of these three PIPs, the SMART Aim goal was achieved and some or all of the quality improvement activities could be linked to the demonstrated improvement. Only one PIP, *Postpartum Care*, was assigned a level of *Low Confidence*. Amerigroup should review HSAG's feedback in this report and in the module feedback forms, seeking technical assistance as needed, to identify strategies for improving the effectiveness of all of its PIPs going forward. Additionally, the CMO should keep in mind the cyclical nature of effective improvement strategies and take action accordingly in areas identified for improvement. For those PIPs that achieved the level of *High Confidence*, the CMO should continue to monitor interventions and outcomes to facilitate long-term, sustained improvement beyond the life of the PIP. The CMO should also continue to implement PDSA cycles as a method of supporting ongoing improvement. Because the rapid-cycle PIPs are focused on a narrow topic and population, the CMO should look for ways to expand interventions with demonstrated success to other populations or to improve other outcomes. PDSA cycles can be used to gradually ramp up intervention dissemination while assessing level of improvement and refining strategies.

## Recommendations

HSAG recommends the following for Amerigroup:

- Ensure detailed, accurate, and consistent documentation of intervention testing results and SMART Aim measure results across all applicable modules of the PIP.
- Implement centralized oversight of the data analysis and results reporting for all PIPs so that all rates are reported accurately and consistently. SMART Aim measure baseline and goal rates, and rate results should be reported to the same number of decimal places for all PIPs. HSAG recommends reporting all PIP rates to one decimal place.

- As Amerigroup tests new interventions, the CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep everyone involved in the project focused on the theory for improvement.
- Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.
- Continue to incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.
- Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.
- For PIPs that successfully demonstrated real improvement, Amerigroup should continue to monitor outcomes beyond the life of the PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the CMO to continually refine interventions to achieve and sustain optimal outcomes.
- For PIPs that identified effective interventions, Amerigroup should pursue avenues for spreading effective interventions beyond the initial scope of the rapid-cycle PIP. The CMO should identify new populations, facilities, or outcomes that could be positively impacted by the interventions. PDSA cycles should be used to test and gradually ramp up intervention dissemination to broader settings.

# Appendix A. PIP Performance Summary Table

**Table A-1—CY 2016 PIP Performance Summary**

| PIP Title | SMART Aim Measure | Baseline Rate | SMART Aim Goal Rate | Highest Rate Achieved | Confidence Level |
|---|---|---|---|---|---|
| *Bright Futures* | The percentage of members in Chatham County that received a 9-month developmental screening | 63.3% | 73.3% | 87.5% | *High Confidence* |
| *Member Satisfaction* | The percentage of members serviced at Toccoa Clinic who answered question 18, "In the last six months, how often did your child's personal doctor listen carefully to you?" with the response, "Always" | 76.0% | 90.0% | 100.0% | *High Confidence* |
| *Postpartum Care* | The percentage of members who received care from The Longstreet Clinic, delivered a live birth, and completed a postpartum follow-up visit within 21–56 days of the birth | 76.5% | 86.5% | 79.0% | *Low Confidence* |
| *Provider Satisfaction* | The percentage of providers invited to provider orientation who reported being satisfied with the orientation | 24.0% | 60.0% | 67.0% | *Confidence* |

# Appendix B. PIP-Specific Module Feedback Forms

Appendix B contains Amerigroup's CY 2016 PIP Validation Feedback Forms—Modules 4 and 5.

# Module 4—Plan-Do-Study-Act (PDSA) for Each Intervention
## *Bright Futures* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The team provided details on each intervention tested (who, what, where, when, why, and how). | X | | The CMO tested the following intervention: monthly fax communication with primary care providers in Chatham County to provide education on eligible members assigned to the provider who were due for a nine-month developmental screening. |
| 2. The interventions that were developed and tested addressed at least one or more of the key drivers, identified failures, or other identified opportunities for improvement. | X | | The CMO linked the intervention to the following key drivers in the key driver diagram and failure mode from the failure modes and effects analysis (FMEA).<br>• Primary driver: Provider Compliance<br>• Secondary driver: Provider Education and Engagement<br>• Failure mode: Provider realizes too late that the member has not scheduled an appointment by the recommended age and therefore misses the opportunity for a preventive visit. |
| 3. The documentation included the data source(s) for each intervention and detailed the data collection process. (Where are the data being collected, who is collecting the data, how are the data being collected, how are the data being calculated, and what are the predicated results?) | X | | The CMO documented an appropriate data collection process and the data sources used for the intervention testing methodology. |

## Appendix B. State of Georgia
## CY 2016 *Bright Futures*—Module 4 Feedback Form
## *for* Amerigroup Community Care

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 4. The documentation included the tracking of events/activities and any challenges and/or confounding factors identified. | X | | The CMO included the intervention tracking tool and documented intervention-related activities, challenges, and identified solutions. |
| 5. The team provided an accurate summary of findings. (Were the metrics and methods used correctly, was the intervention effective, and did the intervention impact the SMART Aim?) | X | | The CMO provided an accurate summary of findings. |
| 6. The key driver diagram, FMEA, and interventions were revised appropriately based on analysis of findings. | X | | The CMO included the key driver diagram and FMEA, updated based on the analysis of findings, in the Module 5 submission form. |
| 7. Successful interventions were expanded and supported by rationale. Unsuccessful interventions were adapted or abandoned and decisions made were supported by rationale. | X | | The CMO chose to adapt the intervention and test it further. |
| 8. The team submitted the final PDSA run/control charts illustrating the effect of the intervention(s). | X | | The CMO included the PDSA run charts illustrating the effect of the intervention. |

# Module 5—Performance Improvement Project (PIP) Conclusions
## *Bright Futures* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The narrative summary of overall key findings and interpretation of results was accurate. | X | | The CMO provided an accurate summary of key findings. |
| 2. The PIP demonstrated evidence of achieving the SMART Aim goal. | X | | The SMART Aim measure (percentage of members in Chatham County who were due for a nine-month developmental screening and received a screening) exceeded the goal rate of 73.3 percent for five consecutive monthly measurements. |
| 3. The CMO documented a plan summarizing how it will evaluate sustained improvement beyond the SMART Aim end date. | X | | The CMO documented a plan for evaluating sustained improvement beyond the SMART Aim end date. |
| 4. The CMO documented its plan for evaluating the expansion of successful interventions beyond the initial scope of the project. | X | | The CMO documented a plan for enhancing and expanding the intervention beyond the initial scope with continued evaluation going forward. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 5. The CMO documented lessons learned. | X | | The CMO documented the following lessons learned:<br>• Qualitative feedback from participating providers suggested that the manual data collection process required for the PIP may have reduced the provider response rate.<br>• Using the EHR (electronic health record) as a means for communicating members due for the nine-month developmental screening may be more convenient for providers than the manual process used during the PIP.<br>• Automating communication between the CMO and providers regarding members due for the nine-month developmental screening is likely to benefit providers, members, and the CMO by reducing the burden of data collection and allowing providers to focus more time on caring for members. |

## HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

☒ **High confidence**

High confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

☐ **Confidence**

Confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

☐ **Low confidence**

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

☐ **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

| **Summary of Validation Findings:** |
| --- |
| The CMO tested one intervention for the PIP: faxing lists of members due for a nine-month developmental screening to primary care providers in Chatham County. The CMO used the SMART Aim measure (percentage of members in Chatham County who were due for a nine-month developmental screening and received a screening) to test the intervention and also collected process data on the provider response rate to the faxed member lists. The SMART Aim measure was appropriate to evaluate intervention effectiveness because the intervention included all members eligible for the measure. The CMO used the provider response rate to examine the administrative burden of the intervention on providers and to determine reasons members did not receive the nine-month screening. The CMO tested the intervention for six months, from June through November, and the SMART Aim goal of 73.3 percent was exceeded for five consecutive months from July through November. The CMO concluded that the intervention was successful; however, it determined that the intervention needed to be adapted to address the administrative burden and increase buy-in from participating providers, as a next step. Because the SMART Aim goal was achieved and the demonstrated improvement was clearly linked to the quality improvement process implemented by the CMO, the PIP was assigned a level of *High Confidence*. |

# Module 4—Plan-Do-Study-Act (PDSA) for Each Intervention
## *Member Satisfaction* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The team provided details on each intervention tested (who, what, where, when, why, and how). | X | | The CMO provided the details for testing the following intervention: partnering with Merck & Co., Inc., to train providers at the targeted clinic on the teach-back method for improving communication between providers and members. The technique has demonstrated effectiveness in ensuring providers are listening, communicating effectively, and helping members understand and remember information provided during the appointment. |
| 2. The interventions that were developed and tested addressed at least one or more of the key drivers, identified failures, or other identified opportunities for improvement. | X | | The CMO linked the intervention to one key driver in the key driver diagram and two failures from the failure modes and effects analysis (FMEA).<br>• Key driver: Members do not understand the explanation or direction given to them by their providers.<br>• Failures:<br>– Doctor does not read back the question to validate he or she understands the member's question.<br>– Doctor does not consider this member might not understand the treatment plan, so he or she moves on to the next visit. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 3. The documentation included the data source(s) for each intervention and detailed the data collection process. (Where are the data being collected, who is collecting the data, how are the data being collected, how are the data being calculated, and what are the predicated results?) | X | | The CMO documented a sound data collection methodology and data sources for evaluating the effectiveness of the intervention. |
| 4. The documentation included the tracking of events/activities and any challenges and/or confounding factors identified. | X | | The CMO included the intervention tracking tool and documented intervention-related activities, challenges, and solutions. |
| 5. The team provided an accurate summary of findings. (Were the metrics and methods used correctly, was the intervention effective, and did the intervention impact the SMART Aim?) | X | | The CMO accurately reported the summary of intervention testing results. |
| 6. The key driver diagram, FMEA, and interventions were revised appropriately based on analysis of findings. | X | | The CMO provided the revised key driver diagram based on the analysis of findings in Module 5. The CMO documented that no updates to the FMEA were necessary. |
| 7. Successful interventions were expanded and supported by rationale. Unsuccessful interventions were adapted or abandoned and decisions made were supported by rationale. | X | | The CMO's decision to adapt the intervention was supported by the summary of findings. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 8. The team submitted the final PDSA run/control charts illustrating the effect of the intervention(s). | X | | The CMO provided the run chart results for the process measure and the SMART Aim measure, with the intervention plotted, illustrating the effect of the intervention. |

# Module 5—Performance Improvement Project (PIP) Conclusions
## *Member Satisfaction* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The narrative summary of overall key findings and interpretation of results was accurate. | X | | The CMO's summary of overall key findings and interpretation of results were accurate. |
| 2. The PIP demonstrated evidence of achieving the SMART Aim goal. | X | | Following the intervention, five of the six monthly SMART Aim measurements met or exceeded the goal of 90.0 percent for the percentage of eligible members answering "Always" to the phone survey question, "In the last six months, how often did your child's personal doctor listen carefully to you?" |
| 3. The CMO documented a plan summarizing how it will evaluate sustained improvement beyond the SMART Aim end date. | X | | The CMO documented a plan for evaluating sustained improvement in Module 4. The CMO stated that it would follow-up with the providers who received the teach-back method training and conduct provider-specific analyses of the monthly member satisfaction results to identify providers who may need further training or support to improve communication and member satisfaction. |
| 4. The CMO documented its plan for evaluating the expansion of successful interventions beyond the initial scope of the project. | | | Not applicable. The CMO reported that while the intervention was successful, effectiveness could be further improved by incorporating lessons learned from the initial test results. The CMO planned to adapt the intervention; therefore, evaluating expansion of the intervention beyond the scope of the initial project did not apply. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 5. The CMO documented lessons learned. | X | | The CMO reported the following lessons learned:<br>• Listening is only one component of effective communication. Additional components include demonstrating respect for the member and providing easy-to-understand explanations during the appointment.<br>• Other factors impacting member satisfaction at the provider level include the patient-to-provider ratio for a clinic and changes in the leadership of the clinic.<br>• The inability to reach members by phone to complete the satisfaction survey continued to be a barrier; however, the survey response rate for the PIP (22 percent) was similar to historic response rates for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) phone survey. |

## HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

☒ **High confidence**

High confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

☐ **Confidence**

Confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

☐ **Low confidence**

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

☐ **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

| Summary of Validation Findings: |
| --- |
| The CMO tested one intervention for the PIP: training providers at the targeted clinic on the teach-back method for improving communication between providers and members. To test the intervention, the CMO tracked which providers received the training and which members experienced the teach-back method during a visit with one of the trained providers. Phone survey data from these members on their satisfaction with provider listening were collected and measured monthly. The CMO compared monthly performance on the intervention-specific measure of effectiveness with overall SMART Aim measure performance and concluded that the intervention was effective. The intervention-specific measure of effectiveness met or exceeded the goal of 90.0 percent for four of six monthly measurements after the intervention occurred, and all measurements following the intervention were above the baseline rate. The SMART Aim measure met or exceeded the goal of 90.0 percent for five of six monthly measurements following the intervention. Based on the summary of findings, the CMO determined the intervention was successful. The CMO provided a sound rationale for adapting the intervention to incorporate some of the lessons learned and address additional components of provider-member communication that can impact member satisfaction, such as demonstrating respect and providing easy-to-understand explanations. The PIP's SMART Aim goal was achieved and the quality improvement processes were clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *High Confidence*. |

# Module 4—Plan-Do-Study-Act (PDSA) for Each Intervention
## *Postpartum Care* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The team provided details on each intervention tested (who, what, where, when, why, and how). | X | | The CMO provided the details for testing the following intervention: live outreach calls conducted by the targeted provider to members who delivered a live birth and were due for a postpartum visit. The CMO provided lists of members who had recently delivered a live birth to the targeted provider to initiate outreach activities. The outreach calls were conducted within 21 days of the birth date and included education on the postpartum visit and scheduling of the visit within 21–56 days following the birth. |
| 2. The interventions that were developed and tested addressed at least one or more of the key drivers, identified failures, or other identified opportunities for improvement. | X | | The CMO linked the intervention tested to the following key driver from the key driver diagram:<br>• Member Engagement |
| 3. The documentation included the data source(s) for each intervention and detailed the data collection process. (Where are the data being collected, who is collecting the data, how are the data being collected, how are the data being calculated, and what are the predicated results?) | X | | The CMO documented an appropriate data collection process and the data sources used for the intervention testing methodology. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 4. The documentation included the tracking of events/activities and any challenges and/or confounding factors identified. | X | | The CMO included the intervention tracking tool and documented intervention-related activities, challenges, and solutions. |
| 5. The team provided an accurate summary of findings. (Were the metrics and methods used correctly, was the intervention effective, and did the intervention impact the SMART Aim?) | X | | The CMO accurately reported the summary of intervention testing results. The CMO reported both the intervention-specific measure of effectiveness and the SMART Aim measure results, with the timing of the intervention plotted, and discussed how these results were related. |
| 6. The key driver diagram, FMEA, and interventions were revised appropriately based on analysis of findings. | X | | The CMO appropriately revised the key driver diagram and failure modes and effects analysis (FMEA) based on the analysis of findings. The updated key driver diagram and FMEA were included in the Module 5 submission form. |
| 7. Successful interventions were expanded and supported by rationale. Unsuccessful interventions were adapted or abandoned and decisions made were supported by rationale. | X | | The CMO's decision to adapt the intervention was supported by the summary of findings. The CMO reported future plans to test the intervention with one or more of the following adaptations:<br>• Adding a follow-up letter to the live phone outreach<br>• Using the targeted provider's electronic medical record (EMR) platform to incorporate automated emails, text messages, or automated calls<br>• Partnering with providers to promote Amerigroup's member incentive for completing a timely postpartum visit |
| 8. The team submitted the final PDSA run/control charts illustrating the effect of the intervention(s). | X | | The CMO provided the run chart results for the process measure and the SMART Aim measure, with the intervention plotted, illustrating the effect of the intervention. |

# Module 5—Performance Improvement Project (PIP) Conclusions
## *Postpartum Care* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The narrative summary of overall key findings and interpretation of results was accurate. | | X | The CMO's interpretation of the SMART Aim measure results documented in Module 5 were incorrect. The run charts on pages 3 and 5 of Module 5 showed that none of the SMART Aim measure data points achieved the goal throughout the life of the PIP. The CMO's narrative description of the SMART Aim measure results on page 4, however, stated that "The Aim re-measure met SMART Aim 18% of the time." This statement did not align with the SMART Aim measure results presented in the run charts. |
| 2. The PIP demonstrated evidence of achieving the SMART Aim goal. | | X | The SMART Aim measure did not achieve the goal of 86.5 percent for eligible members completing a postpartum follow-up visit within 21–56 days after delivering a live birth. |
| 3. The CMO documented a plan summarizing how it will evaluate sustained improvement beyond the SMART Aim end date. | | | Not applicable. The SMART Aim goal was not achieved; therefore, evaluating sustained improvement did not apply. |
| 4. The CMO documented its plan for evaluating the expansion of successful interventions beyond the initial scope of the project. | | | Not applicable. The SMART Aim goal was not achieved; therefore, evaluating expansion of successful interventions did not apply. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 5. The CMO documented lessons learned. | X | | The CMO documented the following lessons learned:<br>• More frequent team meetings improved consensus building and the capacity for rapid-cycle analysis, and ensured use of a valid data collection methodology.<br>• Improving phone outreach did not address all of the barriers to completing a timely postpartum visit. Newly identified barriers included limitations of delivery billing data in linking the member with the appropriate provider and appointment "no shows."<br>• Provider billing data may be a more effective data source than the CMO's inpatient census data for identifying members eligible for the outreach intervention. |

## HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

☐ **High confidence**

High confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

☐ **Confidence**

Confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

☒ **Low confidence**

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

☐ **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

| Summary of Validation Findings: |
| --- |
| The CMO tested one intervention for the PIP: telephone outreach conducted by the targeted provider, to members who delivered a live birth, to promote and schedule the postpartum visit. The CMO provided lists of members to the targeted provider, based on hospital billing data, and the targeted provider reached out to members within the first 21 days after the birth date. To test the intervention, the CMO collected process data on outreach call volume and the percentage of eligible members outreached who completed a timely postpartum visit, plotting monthly data on a run chart. The test results showed that the provider's outreach call volume increased after the intervention was initiated and the postpartum visit rate was higher among those who received the telephone outreach intervention; however, the intervention was not sufficient to achieve the SMART Aim goal for the PIP. The CMO provided a sound rationale for choosing to adapt the intervention, based on the analysis of findings. Based on lessons learned from the PIP, the CMO plans to incorporate one of the following adaptations and conduct further testing of the intervention: add a follow-up letter to the member, use the provider's EMR platform to conduct automated member follow-up, or partner with the provider to promote the CMO's member incentive for completing a timely postpartum visit. Because the SMART Aim goal was not achieved, the PIP was assigned a level of *Low Confidence*. |

## Module 4—Plan-Do-Study-Act (PDSA) for Each Intervention
## *Provider Satisfaction* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The team provided details on each intervention tested (who, what, where, when, why, and how). | X | | The CMO provided the details for testing the following intervention: live telephone outreach to providers to promote registration for provider orientation and enhanced online provider orientation materials and resources. |
| 2. The interventions that were developed and tested addressed at least one or more of the key drivers, identified failures, or other identified opportunities for improvement. | X | | The CMO linked the intervention to one key driver from the key driver diagram and one failure from the failure modes and effects analysis (FMEA).<br>• Key driver: Provider awareness<br>• Failure: The orientation ends but there are still questions outstanding |
| 3. The documentation included the data source(s) for each intervention and detailed the data collection process. (Where are the data being collected, who is collecting the data, how are the data being collected, how are the data being calculated, and what are the predicated results?) | X | | The CMO documented an appropriate data collection process and the data sources used for the intervention testing methodology. |
| 4. The documentation included the tracking of events/activities and any challenges and/or confounding factors identified. | X | | The CMO included the intervention tracking tool and documented intervention-related activities, challenges, and solutions. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 5. The team provided an accurate summary of findings. (Were the metrics and methods used correctly, was the intervention effective, and did the intervention impact the SMART Aim?) | | X | The CMO's summary of findings contained an error and was missing information:<br>• The CMO did not include the December data point in the intervention testing run charts on pages 10 and 13. Because the process measure data were not provided for December, the intervention could not be linked to the SMART Aim performance for this month of the project.<br>• The CMO's discussion of the Chart 2 results on page 13 in Module 4 includes the statement, "For the phone attempts, 5/8 months (63%) correlate with satisfaction and 3/8 months (37%) do not correlate." Because Chart 2 includes only seven data points from May through November, the percentages describing the data points in Chart 2 should have a denominator of seven, not eight. It appeared that the CMO did not include the December data point from Chart 2 that would have been the eighth data point. |
| 6. The key driver diagram, FMEA, and interventions were revised appropriately based on analysis of findings. | X | | The CMO appropriately revised the key driver diagram based on the analysis of findings. The updated key driver diagram was included in Module 5. |
| 7. Successful interventions were expanded and supported by rationale. Unsuccessful interventions were adapted or abandoned and decisions made were supported by rationale. | X | | Based on the analysis of findings and lessons learned, the CMO provided a sound rationale for adapting the intervention. The CMO reported that the intervention was too resource-intensive and would be adapted for future testing. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 8. The team submitted the final PDSA run/control charts illustrating the effect of the intervention(s). | X | | The CMO provided the run chart results for the process measure and the SMART Aim measure, with the intervention plotted, illustrating the effect of the intervention. |

# Module 5—Performance Improvement Project (PIP) Conclusions
## *Provider Satisfaction* PIP

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 1. The narrative summary of overall key findings and interpretation of results was accurate. | | X | There were several errors in the CMO's summary of overall key findings:<br>• The CMO documented the following statement on page 3 in Module 5: "The new Provider Training Page's phone calls are effective because the trend is moving in the correct direction from 29% to 50%." The statement did not clearly relate to the run chart data provided in Module 5, and the two percentages referenced in this statement did not align with the Module 5 run chart results.<br>• On page 3 of Module 5, the CMO stated that the SMART Aim measure achieved the goal of 60.0 percent for 25.0 percent of the monthly measurements (two out of eight months). This statement did not align with either of the SMART Aim run charts included in Module 5. Both run charts included only seven monthly data points for the SMART Aim measure. The CMO should have included the eighth monthly measurement for December in the run charts to align with the narrative summary.<br>• The run chart on page 4 of Module 5 had the "Intervention Start Marker" located in June. This conflicted with the documentation in Module 4, which stated that the intervention was initiated in May. |

| Criteria | Achieved | Failed | HSAG Feedback and Recommendations |
|---|---|---|---|
| 2. The PIP demonstrated evidence of achieving the SMART Aim goal. | X | | The SMART Aim goal of 60.0 percent for providers invited to provider orientation who reported they were satisfied with the orientation was achieved for two monthly SMART Aim measurements, in June and October. |
| 3. The CMO documented a plan summarizing how it will evaluate sustained improvement beyond the SMART Aim end date. | X | | The CMO documented plans for adapting the intervention and testing it further to evaluate sustained improvement. |
| 4. The CMO documented its plan for evaluating the expansion of successful interventions beyond the initial scope of the project. | X | | The CMO documented plans for adapting and testing the intervention with additional providers, beyond the scope of the initial project. |
| 5. The CMO documented lessons learned. | X | | The CMO documented the following lessons learned:<br>• Individual live outreach to providers was effective at improving satisfaction with the provider orientation; however, it was resource-intensive and inefficient.<br>• A satisfaction survey follow-up question with four levels of responses (i.e., always, usually, sometimes, never) would have provided more meaningful data than the yes/no question that was used for the project.<br>• Providing other survey modes, such as email or text message, in addition to a phone survey may improve the survey response rate. |

## HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:

☐ **High confidence**

High confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

☒ **Confidence**

Confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

☐ **Low confidence**

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

☐ **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

| Summary of Validation Findings: |
| --- |
| The CMO tested one intervention for the PIP: live telephone outreach to promote provider orientation registration and increase awareness of enhanced online provider orientation materials. The CMO tested the intervention by linking process data on successful outreach calls and provider orientation registration to results of a follow-up telephone survey which gauged satisfaction with the CMO's provider orientation process. Following initiation of the intervention, the CMO reported an increase in registration rates for provider orientation. Concurrently, the SMART Aim measure remained above the baseline rate of 24.0 percent for seven consecutive months, and the SMART Aim goal (60.0 percent for the percentage of providers reporting being satisfied with the orientation) was met for two monthly SMART Aim measurements. The CMO determined that the intervention was successful and provided a sound rationale for adapting the intervention, based on lessons learned, and conducting further testing with additional providers. Module 5 contained errors in the CMO's summary of findings. While the errors did not prevent the CMO from demonstrating improvement in the SMART Aim measure and linking the demonstrated improvement to the intervention for the months of May through November, the missing intervention testing data point in December prevented the CMO from linking the SMART Aim measure results to the intervention for the last month of the PIP. The SMART Aim goal was achieved, and some but not all of the quality improvement processes were clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Confidence*. |