



State of Georgia
Department of Community Health
Georgia Families Program

**CY 2015 Performance Improvement
Projects Report**
for
WellCare of Georgia, Inc.

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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 and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State’s Medicaid and CHIP 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 serves all other Medicaid and CHIP managed care members not enrolled in the GF 360[°] program. Approximately 1.3 million beneficiaries are enrolled in the GF program.¹⁻¹

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. WellCare of Georgia, Inc. (WellCare) 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 CMO compliance with State and federal regulations and the validation of CMO performance measures are the other two mandated activities.

These three mandatory activities work together to assess the CMOs’ 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 the CMOs 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) 2015, DCH required its CMOs to conduct eight PIPs and submit the final PIP modules for annual validation in 2016. 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

¹⁻¹ Georgia Department of Community Health. “Georgia Families Monthly Adjustment Summary Report, Report Period: 8/2015.”

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 WellCare's PIPs.

In 2014, DCH and HSAG agreed that a comprehensive overhaul of the PIP implementation and validation process was needed in order to embrace a rapid-cycle improvement process and facilitate more effective improvement efforts by the CMOs in Georgia. Consequently, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement 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. The DCH instructed the CMOs to conduct their rapid-cycle improvement projects over a 12-month period.

To support DCH and the CMOs' efforts, HSAG developed new guidance documents for the rapid-cycle improvement projects including:

- A detailed Companion Guide describing the new 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.

At the start of the new rapid-cycle improvement projects, HSAG conducted introductory webinar training sessions for DCH and the CMOs and, on an ongoing basis, provided extensive technical assistance via conference calls with the CMOs 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 &

¹⁻² Institute for Healthcare Improvement. How to Improve. Available at: <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>. Accessed on: Sept 24, 2015.

Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.¹⁻³

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 CMOs' PIPs for the State of Georgia.

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 spreading 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

For CY 2015, WellCare submitted eight PIPs for validation. All of the PIPs were validated using HSAG’s rapid-cycle PIP validation process. The PIP topics included:

- *Annual Dental Visits*
- *Appropriate Use of ADHD [Attention Deficit Hyperactivity Disorder] Medications*
- *Avoidable Emergency Room Visits*
- *Bright Futures*
- *Comprehensive Diabetes Care*
- *Member Satisfaction*
- *Postpartum Care*
- *Provider Satisfaction*

For each of the eight PIPs conducted in CY 2015, WellCare 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 WellCare for establishing the SMART Aim for each PIP:

- **Specific:** The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **Measurable:** 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?
- **Attainable:** 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)?
- **Relevant:** The goal addresses the problem to be improved.
- **Time-bound:** The timeline for achieving the goal.

Table 1-1 outlines the PIP topics and final CMO-reported SMART Aim statements for the eight 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. WellCare 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
<i>Annual Dental Visits</i>	By December 31, 2015, increase the Annual Dental Visit rate from 49.5% to 54.5% among members 11–18 years of age and residing in Bibb County.
<i>Appropriate Use of ADHD Medications</i>	To increase the 30-day follow-up visit rate combined average for select pediatric practices located in rural southwest Georgia for members 6–12 years of age who have newly prescribed ADHD medication (who have four months negative ADHD medication history) from an average of 39% to an overall average of 49% by December 31, 2015.
<i>Avoidable Emergency Room Visits</i>	Decrease Non-Emergent and Emergent-Primary Care Treatable emergency room visits at Floyd Medical Center ER by 10 percentage points from baseline of 117 visits per 1,000 member months to 105 visits per 1,000 member months for WellCare Medicaid and PeachCare for Kids members assigned to Harbin Clinic by December 31, 2015.
<i>Bright Futures</i>	Increase the rate of Adolescent well-child visits for members 12 up to 21 years of age at AGC Pediatric LLC from 55.96 percent to 60.96 percent by December 31, 2015.
<i>Comprehensive Diabetes Care</i>	By December 31, 2015, increase the HbA1c control (<8.0%) rate for diabetic members 18–75 years of age residing in the North and Central regions of Georgia who are assigned to one of the four selected providers from 16.07 percent to 21.07 percent.

Table 1-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Member Satisfaction</i>	By December 31, 2015, increase the percentage of members responding to phone or field survey questions with a rating of very satisfied or satisfied from 89% to 91%.
<i>Postpartum Care</i>	Increase the Postpartum Visit rate by 10 percentage points from 26.3 to 36.3 for all Medicaid and PeachCare for Kids women who deliver at Grady Memorial Hospital (between the ages of 15–44), who have a postpartum visit within 21 to 56 days of delivery by Dec 30, 2015.
<i>Provider Satisfaction</i>	By December 31, 2015, aim to increase the percentage of Health One Alliance providers who answer “Excellent” or “Very Good” to WellCare’s survey question from 64 percent to 74 percent (10 percentage point increase).

Validation Overview

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

WellCare submitted Modules 1 through 3 for each PIP throughout calendar year 2015. 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. WellCare 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 2015. WellCare submitted Modules 4 and 5 to HSAG on February 29, 2016, for annual validation.

The scoring methodology evaluates whether the CMO executed a methodologically sound improvement project, whether the PIP’s SMART Aim goal was achieved, and whether improvement was clearly linked to the quality improvement processes applied in the 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 WellCare’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 goal. The validation findings for WellCare’s PIPs are presented in Table 2-1 through Table 2-16. 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 goal.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the 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.

Annual Dental Visits

WellCare’s goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the annual dental visit rate among members 11 to 18 years old living in Bibb County. Because the SMART Aim goal was not achieved during the life of the PIP, the PIP was assigned a level of *Low Confidence*. The details of the PIP’s performance leading to the assigned confidence level are described below.

The CMO’s rationale for selecting Bibb County as the targeted geographic area for the PIP and the initial key driver diagram illustrating the content theory behind the PIP were provided in the Module 1 Submission Form. The CMO defined the SMART Aim measure and data collection methodology in the Module 2 Submission Form. 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 Annual Dental Visits**

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of adolescents 11 to 18 years of age who reside in Bibb County that received an annual dental visit	49.5%	54.5%	49.4%	<i>Low Confidence</i>

In the SMART Aim statement, the CMO established a goal of improving the annual dental visit rate among members 11 to 18 years old living in Bibb County by 5 percentage points, from 49.5 percent to 54.5 percent. None of the PIP’s SMART Aim measurements met the goal rate of 54.5 percent. The details of the improvement processes used and the interventions tested are presented in Table 2-2 and in the narrative description below.

**Table 2-2—Intervention Testing
for Annual Dental Visits**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Community dental events	<ul style="list-style-type: none"> • Caretaker priorities • Fear of the dentist • Unknown benefits/costs of seeing the dentist 	Members not knowing the benefits/costs of their dental care	The CMO chose to adapt the community outreach intervention, reporting that it believed the intervention would be successful in conjunction with the mobile dental van, which will be launched in 2016.

WellCare used a process map and FMEA to identify and select interventions to test for the PIP. Based on the process map and FMEA results, the CMO identified two interventions to test: community dental events and a mobile dental van. The CMO reported that unforeseen complexities related to the mobile dental van intervention extended the planning phase required for this intervention and prevented testing in 2015; therefore, the CMO only tested the community dental events intervention.

WellCare’s evaluation plan for testing the community dental events intervention relied on medical encounters data to determine the numerator (number of eligible members who received a dental service) for each monthly measurement. The use of claims and encounter data was not a methodologically sound data source for the monthly PDSA measurements because of the lag-time associated with data completeness. While the CMO accurately described the intervention testing results, the interpretation of the results was not accurate. In summarizing the results, WellCare reported that the intervention reached a total of 15 adolescent members in the targeted county, and none of those members received a dental service after receiving the intervention. Rather than concluding that the intervention was unsuccessful, the CMO reported that the evaluation results were inconclusive due to the claims lag issue. The CMO was continuing to follow three adolescent members who received the intervention but had not yet had a dental service, to determine if claims for dental service encounters were submitted within the 90-day claims lag period following the end of the 2015 PIP. Based on the small number of members who could possibly receive a dental visit and the large size of the eligible population for the PIP, HSAG would have expected the CMO to conclude the intervention was unsuccessful, rather than stating that the evaluation was inconclusive, pending claims run-out in 2016.

The CMO chose to adapt the community outreach intervention, reporting that it believed the intervention would be successful in conjunction with the mobile dental van, which was planned for launch in 2016. The CMO stated that the community outreach events could serve to raise awareness of

the mobile dental van and lead to greater dental visit compliance. Given the intervention evaluation results for the community outreach events, in which only seven eligible targeted members were reached and none received a dental visit as a result of the intervention, the rationale for continuing the outreach events was unclear.

WellCare reported lessons learned at the conclusion of the PIP including:

- Establishing a collaboration between medical and dental providers and community stakeholders was a time-consuming but critical step in developing the foundation for improving dental care and services in the targeted county.
- Developing materials requiring DCH approval resulted in delays for launching the mobile dental van intervention.

Based on the validation findings, HSAG recommends that WellCare review and refine its approach to the *Plan* step of the PDSA process used in Module 4 to test interventions. The measures, data collection process, and data sources for the intervention evaluation plan should be well-defined prior to intervention initiation. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because of the lag-time associated with claims completeness. Unless the CMO can verify that claims lag will not be an issue, measures of intervention effectiveness should rely on alternative data sources that provide more real-time feedback for rapid improvement.

Appropriate Use of ADHD Medications

WellCare's goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among members 6–12 years of age who received an initial ADHD medication prescription from one of the targeted pediatric provider practices in rural southwest Georgia. Because the SMART Aim measure rates were calculated incorrectly, the reported PIP results were not credible. The details of the PIP's performance leading to the assigned confidence level are described below.

The CMO's rationale for selecting providers in rural southwest Georgia as the targeted providers and the initial key driver diagram illustrating the content theory behind the PIP were described in the Module 1 Submission Form. The CMO defined the SMART Aim measure and data collection methodology in Module 2. Table 2-3 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 2-3—SMART Aim Measure Results
for Appropriate Use of ADHD Medications**

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children 6 to 12 years of age who complete a follow-up visit within 30 days of the initial fill after receiving an initial prescription for ADHD medication from select pediatric practices in Southwest Georgia	39.0%	49.0%	56.0%	<i>Reported PIP results were not credible</i>

In the SMART Aim statement, the CMO established a goal of improving the follow-up visit rate among members 6 to 12 years old who received an initial prescription for ADHD medication from a selected provider in rural southwestern Georgia by 10 percentage points, from 39.0 percent to 49.0 percent. The CMO plotted rates that were incorrectly averaged across the providers in the region, rather than calculating valid aggregate monthly rates across providers. Although the SMART Aim run chart included monthly rates exceeding the goal of 49.0 percent, the rates were incorrectly calculated; therefore, the PIP did not demonstrate evidence of achieving the SMART Aim goal. The details of the improvement processes used and the interventions tested are presented in Table 2-4 and in the narrative description below.

**Table 2-4—Intervention Testing
for Appropriate Use of ADHD Medications**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
15-day supply initial ADHD medication prescription	<ul style="list-style-type: none"> Member perception of the importance to make follow-up appointments Provider knowledge or interpretations of best-practice guidelines 	Members having medication remaining from the initial fill past the 30-day follow-up period	Because the CMO incorrectly calculated the monthly rates across multiple provider offices, the CMO did not have accurate data to guide decisions about expanding, adapting, or abandoning the intervention.

WellCare used a process map and FMEA to identify and select interventions to test for the PIP. Based on the process map and FMEA results, the CMO identified one intervention to test: partnering with providers and pharmacies to prescribe and fill a 15-day supply of medication for the ADHD medication initiation phase.

WellCare reported in Module 5 that, due to the excessive burden of real-time data collection from multiple providers, the CMO had to shift from the originally planned manual data collection process to a process using claims data to identify the number of members who completed a 30-day follow-up visit. In

general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because the lag-time associated with claims completeness yields incomplete rates that do not accurately reflect the impact of an intervention in a timely manner.

In addition to relying on claims data for the intervention evaluation, the CMO incorrectly calculated and reported the monthly rates during intervention testing. To calculate an aggregate follow-up visit rate across providers, the CMO should have summed the numerators and denominators across the providers, divided the aggregate numerator by the aggregate denominator, and then multiplied by 100 to calculate the monthly percentage rates. Instead, the CMO calculated the monthly follow-up visit rates for individual providers, summed the provider-specific rates, and divided by the number of providers to calculate an average.

HSAG also identified the following inaccurate statements documented by the CMO for Module 4:

Due to our experience with the seasonality of ADHD medication utilization in the summer, we chose to plot the data points for June, July, and August but exclude them from our intervention results. In these months, children are not going to school, not filling their medication and not going to the physician for a new diagnosis of ADHD.

Based on the run chart on page 12, HSAG determined that the rates for June, July, and August were 35 percent, 35 percent, and 34 percent, respectively. If the CMO's statements were true, and no children were initiating and filling medication during these months, it would not be possible to calculate monthly rates because the denominators would be zero.

WellCare chose to expand intervention testing to the eastern region based on its interpretation of the intervention's success in the southwestern region. The CMO's decision to adopt the intervention was not based on a sound rationale because the PIP results were calculated incorrectly. WellCare documented one lesson learned at the conclusion of the PIP: the necessity of working with a single targeted provider office, rather than multiple provider offices, to reduce the burden of real-time data collection and prevent the reliance on medical claims data as part of the intervention testing plan. Selecting a single provider office for future rapid-cycle PIPs can help to simplify the data collection process and the calculation of rates, since it would not be necessary to aggregate rates from multiple providers. HSAG supports the CMO's pursuit of single providers for future rapid-cycle PIPs; however, the CMO should consider the population size for the selected single provider to ensure a sufficient denominator size for the monthly or weekly measurements. HSAG encourages WellCare to request technical assistance with considering the PIP's population size and SMART Aim measure to ensure a methodologically sound design for future PIPs.

Avoidable Emergency Room Visits

WellCare's goal for the *Avoidable Emergency Room Visits* PIP was to identify and test interventions to reduce the avoidable ER visit rate at Floyd Medical Center among members assigned to Harbin Clinic. The PIP's SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the quality improvement processes could be clearly linked to

improvement in the SMART Aim measure; therefore, 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.

The CMO’s rationale for selecting Harbin Clinic and Floyd Medical Center as the targeted facilities, and the initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The CMO defined the SMART Aim measure and data collection methodology in Module 2. Table 2-5 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 lowest rate achieved for the SMART Aim measure.

**Table 2-5—SMART Aim Measure Results
for Avoidable Emergency Room Visits**

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
Avoidable ER visits per 1,000 member months at Floyd Medical Center ER among members assigned to Harbin Clinic	117 visits per 1,000 member months	105 visits per 1,000 member months	68 visits per 1,000 member months	<i>High Confidence</i>

* The Lowest Rate Achieved is reported for the *Avoidable Emergency Room Visits* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

In the SMART Aim statement, the CMO established a goal of reducing the avoidable ER visit rate at Floyd Medical Center for members assigned to Harbin Clinic from 117 visits per 1,000 member months to 105 visits per 1,000 member months. Five of the PIP’s monthly SMART Aim measurements indicated better performance (i.e., had lower rates) than the goal rate of 105 visits per 1,000 members. The details of the improvement processes used and the intervention tested for the *Avoidable Emergency Room Visits* PIP are presented in Table 2-6 and in the narrative description below.

**Table 2-6—Intervention Testing
for Avoidable Emergency Room Visits**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Telephonic outreach by provider and CMO	<ul style="list-style-type: none"> Member Education Access to Medical Home (Primary Care Providers) 	<ul style="list-style-type: none"> Lack of relationships between new members and their PCPs Lack of member knowledge about appropriate ER use and alternative care setting locations, such as urgent care centers and PCP immediate care clinics 	The CMO chose to abandon the intervention at the end of testing because of the low number of members reached and the inconsistent impact on the SMART Aim measure.
Provider-based member outreach	<ul style="list-style-type: none"> Member Education Access to Medical Home (Primary Care Providers) 	<ul style="list-style-type: none"> Lack of relationships between new members and their PCPs Lack of member knowledge about appropriate ER use and alternative care setting locations, such as urgent care centers and PCP immediate care clinics 	Based on the analysis of findings, the CMO plans to continue testing Intervention 2 (provider-based member outreach calls) with the targeted provider and is exploring options for adapting the intervention to further address the barriers identified during the PDSA cycles.

WellCare used a process map and FMEA in Module 3 to identify and select interventions to test. Based on the process map and FMEA results, the CMO identified two interventions for the PIP: (1) a joint CMO-provider telephone outreach initiative which involved the targeted PCP calling newly enrolled members to provide education on appropriate emergent and urgent care use and the CMO calling members assigned to the targeted PCP who had an ER visit, to provide further education on appropriate use of care options and facilitate a follow-up appointment with the targeted PCP; and, (2) a provider-based outreach initiative which involved the targeted PCP calling members within 48 hours of an ER visit to discuss appropriate use of care and scheduling a recommended follow-up appointment.

WellCare used a two-pronged member outreach approach for the telephone outreach intervention: (1) the targeted clinic called new members assigned to their practice to encourage the scheduling of an initial evaluation appointment and to educate members on appropriate use of different levels of care (e.g., urgent care and emergency care); and, (2) the CMO member outreach coordinator made follow-up calls to members assigned to the targeted PCP who had an avoidable ER visit at the targeted hospital, within 48 hours of the visit, to educate on appropriate ER use and alternatives to ER care, and to facilitate a follow-up visit with the member’s PCP. WellCare used a methodologically sound process to evaluate the two-pronged intervention. To test the first part of the intervention, the CMO used enrollment data to identify new members assigned to the targeted PCP. The targeted PCP manually

tracked the new members who were called and reached for the first component of the outreach intervention and the number that scheduled an initial appointment with the PCP. To test the second part of the intervention, the CMO collected real-time ER hospital census data daily to identify members assigned to the targeted PCP who had visited the ER. The CMO manually tracked the members called and reached for the follow-up calls to eligible members who had an avoidable ER visit. Additionally, the CMO tracked whether those members who were reached scheduled a follow-up PCP visit. Based on the evaluation results, the CMO determined that the impact of the intervention was inconclusive because the avoidable ER visit rate among members assigned to the targeted provider fluctuated above and below the goal rate of 105 avoidable ER visits per 1,000 member months during intervention testing.

Because the evaluation results did not show a consistent impact of the telephone outreach intervention, the CMO adapted the intervention during testing. For example, the outreach intervention was revised to target all members assigned to the targeted PCP clinic who had an ER visit, rather than just members who had an ER visit for a confirmed avoidable diagnosis, based on a discovery about the daily ER census data used to identify members for outreach; it was determined that the census did not provide a primary diagnosis for each member's ER visit. By broadening the focus to all eligible members who had any ER visit, the intervention could avoid missing members because of incomplete diagnosis data on the ER daily census. Ultimately, the CMO chose to abandon the intervention at the end of testing because of the low number of members reached and the inconsistent impact on the SMART Aim measure. Using the lessons learned in the evaluation of the initial member outreach intervention, the CMO designed the second intervention, provider-based member outreach, for testing.

The provider-based member outreach intervention included outreach calls from the targeted PCP office to members within 48 hours of an emergency room (ER) visit at the targeted hospital. The outreach call provided education on appropriate ER use, alternatives to ER care, PCP verification, and scheduling of a PCP follow-up appointment for the member. To evaluate the intervention, the CMO obtained daily ER census data from the targeted hospital to identify members for the provider-based outreach calls. A manual tracking log was used to monitor the members who received an outreach call and those who scheduled and attended a follow-up visit with the targeted PCP practice. The avoidable ER visit rate was calculated for members assigned to the targeted provider practice. Based on the intervention evaluation results, WellCare plans to continue testing the provider-based member outreach with the targeted provider and is exploring options for adapting the intervention to further address the barriers identified during the PDSA cycles. The CMO provided a sound rationale for adapting the intervention through analysis of process data and drill-down analyses of the reasons members identified for visiting the ER, which were plotted on a Pareto chart.

The CMO reported the following lessons learned at the conclusion of the PIP:

- Telephonic outreach by the clinic staff was more successful at reaching and educating the member than telephonic outreach by the CMO. The provider had a more established relationship with some members and, therefore, was more likely to reach the member. Additionally, the provider could more readily schedule necessary appointments directly for the member.

- Based on the PIP’s PDSA results, which showed that most avoidable ER visits were not repeat visits, future improvement efforts will focus on preventing avoidable visits among all members, rather than targeting repeat utilizers.
- Future improvement efforts may focus on seeking appropriate care for a subset of avoidable diagnoses (e.g., upper respiratory infections and pain-related complaints) that were most commonly observed.
- The CMO’s processes for identifying key drivers and failure modes for future PIPs will include the analysis of member and/or provider survey data and input to provide a more complete picture of the factors impacting avoidable ER utilization, and support the development of interventions for testing.

Due to WellCare’s success at applying the rapid-cycle PIP methodology in the *Avoidable Emergency Room Visits* PIP, HSAG recommends that the CMO consider how the PIP’s team may be able to share best practices with the CMO’s other PIP teams to facilitate success in future improvement projects.

Bright Futures

WellCare’s goal for the *Bright Futures* PIP was to identify and test interventions to improve the rate of members 12 to 21 years of age, assigned to AGC Pediatric LLC, who received an annual well-child visit. Although the SMART Aim goal was achieved, one intervention was poorly executed and the quality improvement processes could not be clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP’s performance leading to the assigned confidence level are described below.

The CMO’s rationale for selecting AGC Pediatric LLC as the targeted provider and the initial key driver diagram illustrating the content theory behind the PIP were documented in Module 1. The CMO defined the SMART Aim measure and data collection methodology in Module 2. Table 2-7 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 *Bright Futures*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of adolescents 12 to 21 years of age assigned to AGC Pediatric LLC who received an annual well-child visit	56.0%	61.0%	70.0%	<i>Low Confidence</i>

In the SMART Aim statement, the CMO established a goal of improving the annual adolescent well-child visit rate among members assigned to AGC Pediatric, LLC, by 5 percentage points, from 56.0 percent to 61.0 percent. One of the PIP’s monthly SMART Aim measurements exceeded the SMART

Aim goal of 61.0 percent. The details of the improvement processes used and the intervention tested for the *Bright Futures* PIP are presented in Table 2-8 and in the narrative description below.

**Table 2-8—Intervention Testing
for *Bright Futures***

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Member outreach	<ul style="list-style-type: none"> Members not certain how to use benefits, new to Medicaid Value of the visits not understood by parents and adolescents 	Member apathy	The CMO provided a sound rationale for adapting the intervention and moving onto testing the planned intervention revision of adding a member incentive component.
Member outreach and incentive	<ul style="list-style-type: none"> Members not certain how to use benefits, new to Medicaid Value of the visits not understood by parents and adolescents 	Member apathy	<p>The CMO chose to adopt the intervention based on two results:</p> <ol style="list-style-type: none"> The SMART Aim measure exceeded the goal for one monthly measurement on 10/1/15. An analysis of monthly claims data for the targeted provider for 2014 and 2015 showed that the adolescent well-child visit rate for the targeted provider increased at a more rapid rate during the months when the intervention was tested.

WellCare used a process map and FMEA to identify and select interventions to test. Based on the process map and FMEA results, the CMO identified two interventions for the PIP. Both were member outreach initiatives, with one initiative including a gift card incentive for completing an adolescent well-child visit.

For the first member outreach initiative, the CMO partnered with the targeted provider to identify adolescent members who were due for a well-child visit. The intervention entailed telephone calls to adolescent members and their parents. The phone calls offered education on the importance of well visits and scheduling assistance via three-way conference call with the provider office. WellCare used a combination of claims data and manual data collection from the targeted provider to identify adolescent members assigned to the provider who were due for a well-child visit. The CMO collaborated with the targeted provider to collect real-time data on the number of adolescent members who received the intervention and completed a well-child visit. Only one monthly measurement was plotted on the intervention run chart because of unexpected events that occurred during the deployment of the intervention. Because the outreach coordinator did not follow the intervention deployment plan and

communicated the member incentive during outreach calls beginning in mid-June, WellCare had no choice but to progress to the second planned intervention earlier than planned and to abandon testing of the member outreach initiative alone.

For the member outreach initiative with incentive intervention, WellCare partnered with the targeted provider to identify and contact adolescent members who were due for a well-child visit. Telephone outreach offered the same education and scheduling assistance as offered in the first intervention, with the addition of offering eligible members a \$30 gift card for completing the well-child visit. Although the CMO clearly documented how eligible members were identified for the intervention and how the outreach phone calls and completed well-child appointments were tracked, the CMO did not report a process for tracking whether members requested or received the incentive after completing a well-child visit. It was unclear how the impact of adding the incentive could be assessed if information on the number of incentives requested and received was not tracked. The CMO chose to adopt the intervention based on two evaluation results:

- The SMART Aim measure exceeded the goal for one monthly measurement on 10/1/15.
- An analysis of monthly claims data for the targeted provider for 2014 and 2015 showed that the adolescent well-child visit rate for the targeted provider increased at a more rapid rate during the months when the intervention was tested.

The CMO reported the following lessons learned at the conclusion of the PIP:

- The importance of stressing fidelity to the intervention roll-out plan to all staff members and external partners involved in testing the intervention. The unplanned communication of the potential member incentive prior to the planned testing date for adding the incentive caused the CMO to abandon testing of Intervention 1 (member outreach and engagement without an intervention) prior to completing the full testing cycle.
- To maintain the desired sample size of 50 members for the monthly SMART Aim measurements, it was necessary to identify an oversample of potentially eligible members, to allow for individuals who were determined ineligible when contacted for the intervention.

While these two results supported the decision to adopt the intervention, several factors were not addressed by the CMO:

- WellCare was unable to document data on intervention effectiveness beyond October 2015, so data were incomplete for the calendar year of the PIP.
- WellCare reported that the quality department's quality improvement (QI) coordinator was unable to continue the member outreach component of the intervention through the end of CY 2015 "because of a lack of external resources and competing priorities" and the module submissions did not describe how these barriers would be overcome so that the intervention could be continued and adopted.

HSAG's validation findings for the *Bright Futures* PIP illustrate the importance of planning and communication prior to the initiation of intervention testing in the PDSA cycle. The CMO should ensure

that future improvement efforts are preceded by clear communication with partnering providers about the intervention to be tested and the plan for rolling out staggered improvement strategies, such as member outreach and member incentives. Additionally, the CMO should ensure that appropriate measures of effectiveness are clearly defined prior to intervention initiation. The data sources of those measures should be readily accessible, and the measures should clearly demonstrate the impact of intervention components on observed outcomes.

Comprehensive Diabetes Care

WellCare’s goal for the *Comprehensive Diabetes Care* PIP was to identify and test interventions to improve the percentage of diabetic members residing in the North and Central regions of Georgia assigned to one of four selected providers who had an HbA1c test result less than 8.0 percent. Because the SMART Aim goal was exceeded, and because some but not all of the improvement could be linked directly to the improvement activities, the PIP was assigned a level of *Confidence*. The details of the PIP’s performance leading to the assigned confidence level are described below.

The CMO’s rationale for selecting the North and Central regions of Georgia as the targeted geographic area, and the initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The CMO defined the SMART Aim measure and data collection methodology in Module 2. Table 2-9 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 2-9—SMART Aim Measure Results
for Comprehensive Diabetes Care**

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 18 to 75 years of age residing in the North and Central regions of Georgia assigned to one of the four selected providers who had HbA1c control <8.0%.	16.1%	21.1%	54.6%	<i>Confidence</i>

In the SMART Aim statement, the CMO established a goal of improving the percentage of diabetic members in the North and Central regions of Georgia, assigned to one of the selected providers, with an HbA1c result less than 8.0 percent by 5 percentage points, from 16.1 percent to 21.1 percent. Six consecutive monthly SMART Aim measurements met or exceeded the goal of 21.1 percent. The details of the improvement processes used and the interventions tested are presented in Table 2-10 and in the subsequent narrative description.

**Table 2-10—Intervention Testing
for Comprehensive Diabetes Care**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Monthly provider summits	<ul style="list-style-type: none"> • Provider engagement • Adherence to WellCare’s Diabetes clinical practice guidelines • Monthly surveillance of clinical data for diabetic members 	Providers were unable to improve glycemic control of their diabetic members as measured by HbA1c.	The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.
Disease management (DM) engagement	<ul style="list-style-type: none"> • Diabetes awareness • Member education and diabetes-specific management programs 	Members were unaware of how to control their HbA1c.	The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.

WellCare used a process map and FMEA to identify and select interventions to test for the PIP. Based on the process map and FMEA results, the CMO identified two interventions for the PIP: monthly provider education summits for the three targeted providers and active enrollment in DM for diabetic members assigned to the three targeted providers.

The monthly provider summits included training from various WellCare departments and from select in-network specialty providers. The targeted participating providers “were equipped with proprietary tools which helped enhance glycemic control for diabetic patients.” Additionally, the summits provided an opportunity to discuss “barriers, best practices and lessons learned to improve diabetic patient care.” To test the effectiveness of the provider summits, WellCare worked collaboratively with the targeted provider practices to identify diabetic members enrolled and assigned to the targeted providers for the denominator. The numerator (number of diabetic members assigned to the targeted providers who had an HbA1c test result < 8.0%) was tracked monthly using a manual data collection tool. The intervention was at the provider level; therefore, the SMART Aim measure was an appropriate measure for evaluating intervention effectiveness because it was reasonable to assume that all members assigned to the targeted providers received the intervention and could be impacted by it. The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.

For the DM engagement intervention, WellCare sought to enroll and actively engage diabetic members assigned to the targeted providers in the CMO’s DM program, which provided education, guidance, support, and health coaching. The DM program taught self-management skills to address glycemic control and support healthier life choices. The CMO used two measures to evaluate the effectiveness of the intervention: (1) the percentage of diabetic members assigned to the targeted providers who were

successfully enrolled in the DM program, and (2) the SMART Aim measure (percentage of diabetic members assigned to the targeted provider who had a HbA1c result < 8.0%). While both of these measures were relevant, the evaluation plan was missing a measure of the specific effectiveness of DM program enrollment on HbA1c control. The evaluation plan should have included a measure of the percentage of diabetic members who were successfully enrolled in the DM program that had an HbA1c result < 8.0%. Without an intervention-specific measure of the outcome, limited to those members who received the intervention (DM program enrollment), it was not possible to clearly assess the impact of the intervention on the SMART Aim measure. The percentage of members enrolled in the DM program increased more than 20 percentage points, and the SMART Aim measure increased substantially during intervention testing. Based on these results, WellCare chose to adopt the DM engagement intervention.

The CMO documented the following lessons learned at the conclusion of the PIP:

- A more efficient method to collect the provider's laboratory data on HbA1c test results is needed.
- The most prominent barrier to enrolling members in DM services was obtaining accurate member contact information. The CMO will continue to work with providers to leverage their assistance in obtaining accurate and updated member contact information.
- Collaboration between the provider and the CMO was essential to the success of the interventions and the PIP outcomes.

Although the *Comprehensive Diabetes Care* SMART Aim measure exceeded the goal rate for six consecutive monthly measurements during the life of the PIP, the lack of an intervention-specific measure of intervention effectiveness for the DM engagement intervention prevented the intervention from being clearly linked to the demonstrated improvement. HSAG encourages WellCare to ensure appropriate measures of effectiveness are used for the PDSA cycles in ongoing and future PIPs. The CMO can apply the feedback provided in this report and seek additional technical assistance, as needed, to ensure the appropriate measures are selected prior to initiating future interventions.

Member Satisfaction

WellCare's goal for the *Member Satisfaction* PIP was to increase the percentage of members who answered "Satisfied" or "Very Satisfied" to the survey question related to satisfaction with customer service received from the CMO. Although the SMART Aim goal was achieved, the CMO used an invalid SMART Aim measurement methodology, which prevented the CMO from reporting valid results; therefore, the reported PIP results were not credible.

The CMO's initial key driver diagram illustrating the content theory behind the PIP was described in Module 1. The CMO's originally approved SMART Aim measure definition and data collection methodology were described in Module 2, and the CMO's explanation for changing the SMART Aim measure data collection methodology was provided in Module 4-2. Table 2-11 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 2-11—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 responding to phone or field customer service satisfaction survey questions with a rating of “very satisfied” or “satisfied.”	89.0%	91.0%	100%	<i>Reported PIP results were not credible</i>

In the SMART Aim statement, WellCare established a goal of increasing the percentage of members responding to the customer service satisfaction survey questions with an answer of “satisfied” or “very satisfied” by 2 percentage points, from 89.0 percent to 91.0 percent. The CMO reported that the SMART Aim measure met or exceeded the goal of 91.0 percent for five monthly measurements. Because the SMART Aim measure data collection process was changed from the process HSAG approved in Module 2, the results were not based on the approved measurement methodology and were not credible. The PIP did not demonstrate evidence of achieving the SMART Aim goal because the SMART Aim measurement methodology was flawed.

**Table 2-12—Intervention Testing
for Member Satisfaction**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Customer service agent training on handling member eligibility lag between State and CMO	Customer service training and tools	The high volume of member eligibility calls due to system eligibility discrepancies.	The CMO chose to abandon the intervention based on the analysis of findings, due to the lack of evidence of effectiveness.
Customer service representative adherence to member call protocols, resources, and tools	<ul style="list-style-type: none"> Customer service training and tools Member education and engagement 	<ul style="list-style-type: none"> Customer Service does not educate members on roles and responsibilities of WellCare versus the State to minimize confusion before referring them to Compass.org. Customer Service is not provided updated information and resources relative to market trends to enable first call resolutions. 	The CMO chose to adapt and continue to monitor the intervention based on the analysis of findings.

WellCare used a process map and FMEA to identify and select interventions to test. Based on the process map and FMEA results, the CMO identified two interventions for the PIP: (1) customer service

agent (CSA) training and tools to handle member calls related to lagging eligibility (i.e., members are not eligible in the CMO system until the first day of the month following eligibility with the State), and (2) CSA training to improve adherence to established protocols and scripts for the top-five member call issues.

The purpose of the first CSA training intervention was to provide CSAs with the knowledge, skills, and tools needed to deal with the high volume of member calls related to the eligibility lag between the State system and the CMO's system (members are not eligible for coverage with the CMO until the first day of the month following eligibility in the State system). The intervention involved training CSAs on how to explain the eligibility discrepancy to members so that member frustration and repeat eligibility-related calls would be reduced. The evaluation plan documented for the intervention in Module 4 lacked sufficient detail for HSAG to validate whether the data collection process was methodologically sound. The CMO stated that it would be using quality audits (QAs) and first call resolution (FCR) to evaluate the effectiveness of the CSA training. The CMO did not, however, document how specific measures related to QA and FCR would be calculated and analyzed to evaluate intervention effectiveness. The CMO's summary of findings in Module 4 also lacked sufficient detail and did not align with the CMO's documented evaluation plan. The CMO did not provide a narrative summary of results for the *Study* step of the PDSA cycle and instead stated that the intervention was abandoned shortly after initiation because it was determined that the CSA training initiative could not address member satisfaction related to the State-CMO eligibility lag issue.

The purpose of the second CSA training initiative was to increase CSA adherence to established protocols and scripts for the top-five member call issues. By following established protocols, the CSAs were expected to improve interactions with members and, ultimately, improve member satisfaction survey responses. The intervention included CSA education on correct caller practices, customer service workflows, and sensitivity training. The intervention targeted improvement in five high-volume member call issues:

- Properly open/close calls.
- Identify members calling multiple times for the same issue.
- Follow the correct process or step action.
- Complete accurate documentation at the end of calls.
- Complete call drivers within the system.

The data collection process for evaluating the second CSA training initiative was not methodologically sound. The CMO reported that it shifted from relying primarily on a telephone survey methodology to primarily relying on another survey that could be completed by phone or in person at community events. Because telephone and field survey methodologies differ, potentially impacting member responses and biasing results, switching from one methodology to another mid-way through intervention testing is not a methodologically sound data collection process. WellCare compiled the results of both surveys and concluded that the intervention was effective. The CMO chose to adapt and continue to monitor the intervention based on the analysis of findings. Planned adaptations to the intervention include the following:

- Add an incentive program for CSAs who consistently meet standards of call handling behavior.
- Update the current quality audit process to ensure effective, results-driven monitoring of call handling behavior.
- Regularly update applicable call tools and training content for CSAs to align with current customer service protocols and requirements.

The CMO documented the following lessons learned as a result of the PIP:

- Monitoring and auditing the CMO's customer service agent interactions with members was beneficial to the CMO's learning.
- Collecting performance data each month was both necessary and helpful to the CMO's continuous improvement efforts.

Based on the validation findings for the *Member Satisfaction* PIP, HSAG recommends that WellCare review the intervention determination processes used in Module 3 and the four steps of the PDSA process used in Module 4. In Module 3, the CMO should ensure that the process mapping and FMEA activities undertaken by the PIP team are including the appropriate team members and utilizing the appropriate data sources, to ensure that interventions selected for testing address the root causes and barriers to improvement. In Module 4, the CMO should consider seeking technical assistance from HSAG to ensure that the evaluation plan for chosen interventions is methodologically sound and that data sources and measures of effectiveness are clearly defined. If the CMO determines a need to change the evaluation plan for an intervention after it is initiated, WellCare is encouraged to discuss the planned changes with HSAG so that methodological implications can be fully examined and biased results can be avoided.

Postpartum Care

WellCare's goal for the *Postpartum Care* PIP was to identify and test interventions to improve the postpartum visit rate among members 15 to 44 years of age who delivered a live birth at Grady Memorial Hospital. The PIP's SMART Aim goal was achieved; however, some but not all of the quality improvement processes could be clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

The CMO's rationale for selecting Grady Memorial Hospital as the targeted facility and the initial key driver diagram illustrating the content theory for the PIP were described in Module 1. Table 2-13 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 2-13—SMART Aim Measure Results
for Postpartum Care**

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of women 15 to 44 years of age that had a postpartum visit 21 to 56 days after delivering a live birth at Grady Memorial Hospital.	26.3%	36.3%	62.5%	Confidence

In the SMART Aim statement, the CMO established a goal of improving the percentage of women who completed a postpartum visit within 21–56 days after delivering a live birth at Grady Memorial Hospital by 10 percentage points, from 26.3 percent to 36.3 percent. Four of the PIP’s monthly SMART Aim measurements met or exceeded the goal rate of 36.3 percent. The details of the improvement processes used and the interventions tested are presented in Table 2-14 and in the subsequent narrative description.

**Table 2-14—Intervention Testing
for Postpartum Care**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider education	Provider practice	Members did not understand the value of the postpartum visit nor did they distinguish a difference between the incision check and the postpartum visit.	The CMO chose to adopt the intervention based on the analysis of findings.
Member education prior to delivery	Member education (understanding the importance of visit)	<ul style="list-style-type: none"> Member does not understand the importance of the postpartum visit (PPV) being within 21–56 days. Member does not understand the difference between incision check and PPV. 	The CMO chose to adopt and pursue expansion of the intervention based on the analysis of findings.

WellCare used a process map and FMEA to identify and select interventions to test. Based on the process map and FMEA results, the CMO planned two interventions for the PIP: (1) education for the targeted hospital and clinic staff on the importance and requirements of the timely postpartum visit, and (2) education on the postpartum visit provided at 35 weeks gestation to members delivering at the targeted hospital and receiving prenatal care at the hospital’s on-site clinic.

For the provider education intervention, the CMO’s quality improvement nurse offered “train the trainer” educational sessions to administrative and nurse management staff at the targeted hospital. The education was disseminated to staff at the hospital’s on-site clinic and affiliated outlying clinics, where members were expected to obtain the postpartum visit. The education sessions covered HEDIS standards and components of the postpartum visit, and the importance of adhering to the 21–56-day post-delivery timeline. The CMO used a manual tracking tool that tracked the date members delivered, the date of the scheduled postpartum appointment, and whether the appointment was completed. The CMO worked collaboratively with the targeted hospital to identify members who were due for delivery, actual date of delivery, and status of the postpartum visit. The CMO chose to adopt the intervention based on the analysis of evaluation results. HSAG determined, however, that the evaluation results were not valid because the measurement intervals were not consistently spaced. The measurement intervals should have been weekly, biweekly, or monthly so that there was an equal amount of time between each measurement.

For the member education intervention, the CMO partnered with the targeted hospital’s on-site family planning clinic to offer member education at 35 weeks gestation regarding the importance of completing the postpartum visit within 21–56 days post-delivery, and the difference between a C-section incision check appointment and the postpartum visit. To test the intervention, the CMO used a manual tracking tool that tracked members who delivered, whether the member received postpartum visit education at 35 weeks’ gestation, whether a postpartum appointment was scheduled, and whether the appointment was completed. The CMO worked collaboratively with the targeted hospital to identify members who were due for delivery, actual date of delivery, and status of the postpartum visit. The targeted clinic tracked whether education occurred at 35 weeks’ gestation. The CMO plotted the monthly percentage of members delivering at the targeted hospital that received education at 35 weeks and completed a postpartum visit. The timely postpartum visit rates increased from 30 percent to 55 percent to 58 percent, respectively, during the three months of testing; as a result, the CMO chose to adopt the intervention and pursue expansion.

The CMO documented the following lessons learned about the barriers encountered while working with a large institution (hospital) as the targeted provider for the PIP:

- Multiple provider training sessions were required because of the number of clinics providing postpartum visits for members delivering at the targeted hospital.
- Revolving staff (residents) created needs for additional training efforts and outreach.
- Senior leadership changes at the institution impacted the improvement efforts.
- Data exchange with a large institution was challenging.

HSAG recommends that WellCare apply the lessons learned in the *Postpartum Care* PIP when selecting partner providers for future improvement efforts. HSAG also recommends that the CMO pay particular attention to the evaluation plan during the *Plan* step of the PDSA cycle. When planning measurement intervals for PDSA cycles, the intervals should be consistent throughout the testing cycles. Additionally, the more frequently the CMO can measure results, the more rapidly patterns can be identified to refine the intervention and drive improvement in the outcomes.

Provider Satisfaction

WellCare’s goal for the *Provider Satisfaction* PIP was to identify and test interventions to increase overall satisfaction with the CMO among Health One Alliance providers. The SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the quality improvement processes could be clearly linked to improvement in the SMART Aim measure; therefore, 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.

The CMO’s rationale for selecting Health One Alliance as the targeted provider group and the PIP’s initial key driver diagram illustrating the content theory behind the PIP were described in Module 1. The CMO defined the SMART Aim measure and data collection methodology in Module 2. Table 2-15 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 2-15—SMART Aim Measure Results
for *Provider Satisfaction***

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of Health One Alliance providers who answer “Excellent” or “Very Good” to WellCare’s overall satisfaction survey question.	64.0%	74.0%	76.7%	<i>High Confidence</i>

In the SMART Aim statement, the CMO established a goal of increasing the percentage of Health One Alliance providers who answer “Excellent” or “Very Good” to WellCare’s overall satisfaction survey question. One of the PIP’s SMART Aim measurements exceeded the goal of 74.0 percent. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 2-16 and in the narrative description below.

**Table 2-16—Intervention Testing
for Provider Satisfaction**

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Targeted provider outreach, education, and issue resolution	<ul style="list-style-type: none"> Account management and response Access to claims support team Provider education via Provider Relations Access to the operations account representative 	<ul style="list-style-type: none"> The provider contacted the incorrect person and/or department within WellCare. Issue routed to the incorrect department/person within WellCare. 	The CMO chose to adopt the intervention based on the analysis of findings and is planning a staged expansion guided by a regional analysis of provider satisfaction to identify areas of highest need for improvement.

WellCare used a process map and FMEA to identify and select interventions to test. Based on the process map and FMEA results, the CMO identified one intervention for the PIP: provider education on the provider relations representative’s role and the issue escalation process, with follow-up by the provider relations representatives to ensure timely response and claims issues resolution. The intervention was initiated by providing education to the targeted provider about the provider relations representative and the issue escalation process. The provider relations representative acts as a liaison between the provider and other CMO departments to facilitate timely issue resolution and communicate results back to the provider.

To test the provider outreach intervention, WellCare surveyed the targeted provider biweekly about the provider’s satisfaction with the issue resolution process and overall satisfaction. The CMO plotted the biweekly percentages of targeted provider responses to the three survey questions on three separate run charts. Two of the survey questions assessed satisfaction with areas of the provider issue resolution process directly targeted by the intervention: (1) the rate of satisfaction with timeliness increased in a linear trend from 33.3 percent at the initiation of the intervention to 70.0 percent at the last testing measurement, and (2) the rate of satisfaction with claims resolution increased from 36.7 percent at initiation to 66.7 percent at the last testing measurement. The third question assessed overall satisfaction, with results following a similar trend, increasing from 23.3 percent to 76.7 percent. The CMO chose to adopt the intervention based on the analysis of evaluation results and is planning a staged expansion guided by a regional analysis of provider satisfaction to identify areas in highest need for improvement.

The CMO documented the following lessons learned as a result of the PIP:

- Educating providers and aligning providers with their assigned provider relations representative was an effective strategy for improving response timeliness.
- Timeliness of answering questions and resolving provider issues improves overall provider satisfaction.
- Policies surrounding provider follow-up and response should be reviewed and enforced state-wide.



Given the success of the *Provider Satisfaction* PIP, HSAG recommends that WellCare consider asking the *Provider Satisfaction* PIP team to identify and share best practices with the CMO's other PIP teams. While individual PIPs cannot be directly compared because of the varying topics, eligible populations, and improvement strategies, the CMO may identify approaches or strategies used in the *Provider Satisfaction* PIP that can be translated and applied to other improvement projects.

3. Conclusions and Recommendations

Conclusions

A summary table of WellCare's performance across all eight PIPs, including reported SMART Aim measure rates and the level of confidence HSAG assigned for each PIP, is provided in Appendix A. HSAG determined *High Confidence* for two of the eight PIPs: *Avoidable Emergency Room Visits*, and *Provider Satisfaction*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the quality improvement processes could be clearly linked to the demonstrated improvement.

HSAG assigned the level of *Confidence* to two of WellCare's PIPs, *Comprehensive Diabetes Care* and *Postpartum Care*. The level of *Confidence* was assigned 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.

HSAG assigned a level of *Low Confidence* for two of the CMO's PIPs, *Annual Dental Visits* and *Bright Futures*. The SMART Aim goal was not achieved for the *Annual Dental Visits* PIP, and the SMART Aim goal was achieved for the *Bright Futures* PIP; however, the quality improvement processes could not be clearly linked to the demonstrated improvement.

HSAG determined that for the remaining two WellCare PIPs, *Appropriate Use of ADHD Medications* and *Member Satisfaction*, the CMO's reported PIP results were not credible. In the *Appropriate Use of ADHD Medications* PIP, the CMO calculated the SMART Aim measure rates incorrectly. In the *Member Satisfaction* PIP, the CMO did not use the approved data collection process for the SMART Aim measurements. For both PIPs, incorrect SMART Aim measurement methodology resulted in PIP results that were deemed not credible.

WellCare's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing HSAG's rapid-cycle PIP process, though the CMO's performance varied widely by topic. In addition to incorporating HSAG's feedback from this report and seeking technical assistance from HSAG when planning PDSA cycles, the CMO should also examine the performance of various PIP teams in its organization to determine if best practices for executing rapid-cycle PIPs can be identified within the organization and shared across teams and departments.

Recommendations

HSAG recommends the following for WellCare:

- Ensure detailed, accurate, and consistent documentation of the SMART Aim statement, SMART Aim measure definition, and baseline and goal rates to ensure consistency across all modules.

- If the CMO determines that the SMART Aim statement and/or SMART Aim measure need to be revised after Modules 1 and 2 have been approved by HSAG, the CMO must contact HSAG to discuss planned revisions and any methodological implications. Revisions to an approved SMART Aim statement and/or SMART Aim measure methodology must be clearly documented, including the rationale for the revisions, and submitted to HSAG. All subsequent module submissions should clearly explain any changes that were made to an approved SMART Aim statement and/or measure methodology, including the rationale for the changes.
- Institute 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 results should be reported to the same number of decimal places for all PIPs. HSAG recommends reporting all PIP rates to one decimal place.
- Revisit and update the key driver diagram and FMEA throughout the improvement process. Each version of the key driver diagram and FMEA should be dated to document when it was last revised.
- Conduct multiple sessions to develop and update the process map and FMEA, ensuring appropriate use of data and input from all relevant team members, for each PIP. The accuracy and completeness of the process map and FMEA will serve as the foundation for identifying and developing impactful improvement strategies.
- As WellCare moves through the quality improvement process and conducts additional PDSA cycles, the CMO's PIP team should ensure that it is communicating WellCare's theory about changes that will lead to improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons.
- As WellCare 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 the theory for improvement in the project in the forefront for everyone involved.
- Avoid relying on medical claims as a data source when defining measures to be used in PDSA cycles, unless the CMO has strong evidence that claims lag will be minimal. Seek technical assistance from HSAG when considering the use of medical claims data for PDSA cycles so that methodological implications and potential alternative measures can be discussed.
- 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.
- When planning to test an intervention with multiple steps or components, consider staggering the initiation of the individual steps or components so that the impact of each step or component can be distinguished. A staggered approach to intervention testing may require shorter data collection intervals so that the multiple intervention components can be introduced and tested within the life of the PIP.
- When planning a test of change, WellCare should think proactively (future tests and implementation).
- 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.

Appendix A. PIP Performance Summary Table

Table A-1—CY 2015 PIP Performance Summary

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
<i>Annual Dental Visits</i>	The percentage of adolescents 11 to 18 years of age who reside in Bibb County that received an annual dental visit	49.5%	54.5%	49.4%	<i>Low Confidence</i>
<i>Appropriate Use of ADHD Medications</i>	The percentage of children 6 to 12 years of age who complete a follow-up visit within 30 days of the initial fill after receiving an initial prescription for ADHD medication from select pediatric practices in Southwest Georgia	39.0%	49.0%	56.0%	<i>Reported PIP results were not credible</i>
<i>Avoidable Emergency Room Visits</i>	Avoidable ER visits per 1,000 member months at Floyd Medical Center ER among members assigned to Harbin Clinic	117 visits per 1,000	105 visits per 1,000	68 visits per 1,000 (inverse measure)	<i>High Confidence</i>
<i>Bright Futures</i>	The percentage of adolescents 12 to 21 years of age assigned to AGC Pediatric LLC who received an annual well-child visit	56.0%	61.0%	70.0%	<i>Low Confidence</i>
<i>Comprehensive Diabetes Care</i>	The percentage of members 18 to 75 years of age residing in North and Central regions of Georgia assigned to one of the four selected providers who had HbA1c control <8.0%.	16.1%	21.1%	54.6%	<i>Confidence</i>
<i>Member Satisfaction</i>	The percentage of members responding to phone or field customer service satisfaction survey questions with a rating of “very satisfied” or “satisfied.”	89.0%	91.0%	100%	<i>Reported PIP results were not credible</i>
<i>Postpartum Care</i>	The percentage of women 15 to 44 years of age that had a postpartum visit 21 to 56 days after delivering a live birth at Grady Memorial Hospital.	26.3%	36.3%	62.5%	<i>Confidence</i>
<i>Provider Satisfaction</i>	The percentage of Health One Alliance providers who answer “Excellent” or “Very Good” to WellCare’s overall satisfaction survey question.	64.0%	74.0%	76.7%	<i>High Confidence</i>