

CHCS

Center for
Health Care Strategies, Inc.

A Guide to the BCAP Quality Framework

*An initiative of the Center for Health Care Strategies to improve the quality
and cost effectiveness of Medicaid managed care.*

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a national non-profit organization devoted to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. CHCS advances its mission by working directly with state and federal agencies, health plans, and providers to design and implement cost-effective strategies to improve health care quality.

About BCAP®

Best Clinical and Administrative Practices (BCAP) was developed by CHCS to improve the quality and cost effectiveness of Medicaid managed health care. Health plans, state primary care case management programs, and other Medicaid stakeholders participating in BCAP collaboratives apply the BCAP Quality Framework, a proven methodology that divides quality improvement activities into manageable, measurable, incremental steps. Since April 2000, more than 150 managed care organizations in 37 states have used the BCAP approach to improve health care quality within targeted clinical areas and for select populations.

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About Best Clinical and Administrative Practices

“Many times health care strategists have neglected the nuts and bolts of improving the health status of Medicaid populations. Our BCAP successes clearly show that there are tools and processes that can produce measurable change. This is impressive and encouraging.”

– Susan Beane, MD, Medical Director, Affinity Health Plan, Bronx, New York

Enormous strides have been made to identify, implement, and institutionalize best practices to improve the health care and health outcomes of Medicaid enrollees in managed care health plans. Yet, we all recognize that, given the gaps in quality across the U.S. health care system, the surface has only been scratched.

Best Clinical and Administrative Practices is a CHCS initiative to improve the quality and cost effectiveness of managed health care services primarily in Medicaid. As of April 2006, CHCS has worked with:

- More than 135 health plans in 37 states;
- Five PCCM programs;
- Two EQROs; and
- Eleven additional health care organizations.

BCAP has helped health plans and states improve quality in a variety of areas, including birth outcomes, preventive care services for children, asthma, care for adults and children with special needs, adolescents with serious behavioral health disorders, and early child development services.

Under each BCAP improvement focus area, CHCS has convened one or more workgroup(s) of up to 15 health plans to develop and pilot best practices for improving the delivery of health care to Medicaid enrollees. Health plans in each BCAP workgroup use the BCAP Quality Framework to plan, implement, and evaluate small pilot projects and institutionalize best practices. The framework provides a simple, logical structure for creating and instituting operational change within health plans.

Using the BCAP Quality Framework ensures a consistent process for improvement among health plans serving Medicaid populations. Benefits of adopting the BCAP approach include:

- Creating a culture of change and improvement within managed care organizations and, potentially, within a region or state;
- Leveraging and building plan infrastructure and care management programs;
- Sharing best practices among managed care organizations;
- Creating efficiencies and standardization among plans;
- Fulfilling state Quality Improvement Project requirements;
- Improving quality, financial, outcomes; and
- Improving customer satisfaction.

Based on the demonstrated success of the BCAP approach in helping health plans to design and measure the effectiveness of quality initiatives within Medicaid, CHCS is applying the BCAP approach to new challenges. For example, CHCS is using BCAP as the underlying infrastructure for its efforts to:

- Align multiple stakeholders to improve health care quality, e.g., asthma collaboratives in California, New York, and Indiana, in which CHCS works with the states, their plans, and their providers to reinforce each other's efforts;
- Reduce racial and ethnic disparities with more than 20 national health plans serving 76 million Medicaid and commercial beneficiaries; and
- Demonstrate the business case for improving health care quality through a collaborative of 10 managed care entities that are assessing the return on investment associated with quality enhancing initiatives.

We encourage Medicaid stakeholders to test this proven quality process to effectively target limited resources to reap the greatest gains in improved health care quality and controlled costs.

Building Evidence

BCAP initiatives are assisting Medicaid health plans and providers in successfully adopting existing evidence-based guidelines for care. Where evidence-based practices do not exist, e.g., people with multiple chronic conditions, BCAP initiatives are helping to establish *best practices* and perhaps ultimately, new evidence-based practices for complex populations.

Evidence-based practice emphasizes care that has been proven effective by clinically relevant research. Information about evidence-based best practices is typically disseminated via peer-reviewed medical journals and evidence-based guidelines that are developed to assist practitioners and patients in making appropriate clinical decisions.

Evidence-based guidelines seek to close the gap between current medical/dental knowledge derived from research, and the clinical care that is provided by practitioners. Evidence is usually derived from (in descending order of strength) randomized controlled clinical trials, non-randomized controlled clinical trials, cohort studies, case-control studies, crossover studies, cross-sectional studies, case studies, and consensus opinion of experts in appropriate fields of research or clinical practice.

While quality improvement efforts are increasingly being discussed in the peer-review evidence-based context, a consensus is not yet established regarding whether measurement of quality improvement efforts and related clinical outcomes merit stronger consideration, i.e., as evidence-based research. Recognizing the evolving role of quality improvement activities, CHCS and participating health care entities continue to forge ahead – producing and disseminating *best practices* through quality improvement initiatives. Best practices are those that are not yet tested (or may never be tested) by randomized control trials, but have demonstrated significant measurable improvements in care.

A Guide to the BCAP Quality Framework

“The BCAP framework gives plans a way to think about how to both understand the problems and barriers that they have, as well as to improve them. We have seen tangible improvements in performance rates in the areas that are encompassed by BCAP.”

– Foster Gesten, MD, Medical Director, Office of Managed Care, New York State Department of Health, Albany, New York

The BCAP Quality Framework is a proven quality improvement process that builds on the expertise and experience of many managed care organizations. It is a ground-level tool that parses out quality improvement activities into manageable, measurable, and incremental steps. Many health plans, state Medicaid agencies, primary care case management organizations, and external quality review organizations have enhanced Medicaid managed care services by applying the BCAP Quality Framework. Medical directors embracing the model report a new *culture of measurement* within health plans and an ability to pinpoint the accuracy of quality improvement efforts to benefit Medicaid enrollees.

Elements of the BCAP Quality Framework are adapted from learning models developed by the Institute for Healthcare Improvement and others focusing on chronic disease, e.g., the Improving Chronic Illness Care program at the McColl Institute for Healthcare Innovation. The four components of the BCAP Quality Framework are:

1. BCAP Typology: Enables organizations to structure quality improvement activities to consistently address barriers unique to serving Medicaid enrollees. The categories are:

Identification: How do you identify the relevant population?

Stratification: How do you assign risk, severity, or priority within that population?

Outreach: How do you reach the target population?

Intervention: What changes will you make to improve outcomes?

2. Rapid Cycle Improvement: Encourages participants to set goals and measure progress early and often to make real-time refinements to quality efforts based on preliminary successes or setbacks.¹ Rapid cycle improvement includes:

- *Aim*
- *Measure*
- *Change*
- *Plan-Do-Study-Act Cycles*

3. Measurement and Evaluation: Build realistic measures into quality initiatives to establish baseline data, guide and monitor improvement efforts, and demonstrate the success of change strategies. Pilot measures describe individual improvement team results in each BCAP Typology category. Common measures aggregated across several organizations create normative data.

4. Sustainability and Diffusion: Promote tools to institutionalize and spread best practices to ensure the long-term success of quality efforts.

Conducting a Needs Assessment to Target Quality Improvement Activities

Prior to developing a quality improvement project, health plans need to conduct a needs assessment to target their efforts. A needs assessment can determine priorities among potential quality improvement activities for populations with complex health care needs. This process is not about identifying the care needs of a specific individual (e.g., developing an individual care plan), but rather about identifying a measurable quality improvement goal for which there is likely to be a tangible return on investment.

For example, in developing a project to improve care for adults with disabilities and chronic illnesses, a health plan must decide where it should initially focus its efforts. Should it improve diabetes care for people with serious mental illness? Ensure that members with disabilities have a regular source of primary care? Make better use of limited care coordination resources? As part of the needs assessment process, many health plans review their utilization and claims data. Additional activities that can identify unmet needs include:

- Member surveys or focus groups;
- Provider surveys or interviews;
- A review of the literature;
- The experiences of health plan staff or departments such as member services, utilization review, or case management; and
- Community planning activities or task force recommendations.

¹ G. Langley, K. Nolan, T. Nolan, C. Norman, and L. Provost *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. Jossey-Bass, 1996.

The BCAP Typology

“The BCAP Typology is a simple, yet powerful tool that provides rigor to quality improvement programs. In particular, it focuses on measures that help you to determine whether changes are truly an improvement. BCAP gave us a great deal of credibility when we finally took it to senior management and said, ‘We want you to spend money on this and here’s why.’”

– David Levin, MD, Vice President of Medical Affairs, Sentara Healthcare, Virginia Beach, Virginia

“The Typology is logical and applicable to interventions for any target group for quality improvement.”

– Cynthia Ardans, Quality Monitoring and Improvement Manager, Partnership HealthPlan of California, Suisun City, California

The BCAP Typology categorizes quality improvement activities. It offers a template for designing initiatives that can be customized to address specific clinical and administrative needs. The BCAP Typology, developed based on interviews with chief medical officers and quality improvement directors, is designed to help health plans specifically address the barriers faced in serving Medicaid populations. Adopting the BCAP Typology allows health plans and stakeholders in different environments to share a common language to compare experiences.

BCAP TIP



Using the BCAP Typology

The BCAP Typology can be applied to virtually any clinical area or sub-population to target quality improvement efforts. The following example illustrates the use of the BCAP Typology for children with special needs:

- Identification** How can the health plan identify children with special needs?
- Stratification** How is the identified population of children with special needs stratified by different levels of need or risk?
- Outreach** How does health plan staff effectively reach children with special needs and their families?
- Intervention** What changes are effective to improve outcomes for children with special needs?

Identification

Identifying members with the particular health condition being targeted is the first step toward improving the management of that condition. Questions to consider include:

- What current method(s) does the health plan use to identify members with the condition?
- Can the health plan access various administrative data sources or existing databases? These include paid claims, encounter data, pharmacy data, laboratory results, and trends in complaints and grievances.
- How does the health plan encourage providers and community agencies to assist in identifying members with the condition?
- Does the health plan perform a health risk assessment on all new enrollees to the plan?
- Does the health plan create and regularly update a registry for those members with the condition?

Stratification

Once the health plan has identified its relevant population, how does it determine where to focus quality improvement activities particularly when resources are limited? For example, which members are most at risk of having poor outcomes? Where is the highest potential for return on investment? Which provider sites are likely to adopt change and demonstrate improvement? Questions to consider include:

- Do the targeted recipients have a history of hospitalizations and/or emergency department use for the condition?
- Do pharmacy data indicate poor management of the chronic condition for a subset of the target population?
- Can the health plan access condition-related member surveys to identify high-need recipients?
- Can the health plan access laboratory test results to identify recipients with poor control?
- Does the health plan log member or provider complaints to look for opportunities?
- Are the health plan members within a specific geographic area?
- Which of the health plan members are seen by high-volume providers?

Outreach

Ongoing outreach efforts are critical to ensure members have access to appropriate services and adhere to the management regimens for the condition. Outreach can also include providers who care for the target population. Questions to consider include:

- How does the health plan currently reach its members with the condition?
- How effective is the current outreach approach?
- Does the plan make regular calls to members? Does the plan have a home visiting program or a community presence?
- Does the plan have a system for updating and maintaining member contact information?
- Does the plan seek alternative phone numbers or addresses to use?
- Does the plan design its outreach approaches by taking into consideration the members' cultural and linguistic needs?
- How does the plan reach out to providers to impart new information or to introduce new activities (e.g., letters to providers, academic detailing office visits, etc.)?

Intervention

Once a plan has identified, stratified, and made contact with its pilot project population, what intervention can be offered to improve clinical outcomes and administrative practices? Interventions can be targeted to members or the providers who care for them. Questions to consider include:

- What programs are available to members with the condition who are at risk for poor outcomes? What programs are available for their health care providers?
- Are these programs evidence-based? Cost effective? Culturally sensitive and literacy level appropriate?
- How many members with the condition use the service? What percentage of the total population with the condition does this represent?
- Can the plan document improvements in health outcomes as a result of these programs?
- Has provider behavior changed as a result of the activity? How do you know there is a change?

It is important to note that typology categories may overlap. For instance, identification and stratification often are accomplished in

one step. For example, during a BCAP workgroup, *Enhancing Early Childhood Development in Medicaid Managed Care*, Lovelace Community Health Plan sought to identify its 0-3-year-old members in need of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Lovelace implemented a software program that identified these members, and had the resources to intervene with all of them, thus further stratification of the 0-3-year-old population was not necessary.

It also is common for outreach and intervention to overlap. For example, Lovelace aimed to reach parents of 0-3-year-old members to remind them that their children were due for a well-child visit. Members were sent postcard reminders and a “Well-Child Round Up Day” program was started in provider offices. In addition, Lovelace staff conducted reminder phone calls to parents of children due for well-visits. This member outreach also served as member intervention, since the outreach resulted in increased EPSDT screening rates and referrals.

Rapid Cycle Improvement

Measuring progress early and often provides ample flexibility to refine projects based on preliminary successes and/or setbacks. BCAP uses the Model for Improvement,² which encourages organizations to identify an Aim, Measure, and Change strategy for each quality improvement pilot effort by asking:

Aim: What are we trying to accomplish?

Measure: How will we know that change is an improvement?

Change: What changes can we make that will result in an improvement?

This is followed by rapid PDSA (Plan, Do, Study, Act) cycles to test changes in systems and processes. The PDSA cycles guide teams through a quick-turnaround analysis and improvement process. Typically, the health plan develops an overall Aim for its pilot project, and then develops an Aim, Measure, and Change strategy for each typology category (identification, stratification, outreach, and intervention). This method helps BCAP participants divide quality improvement projects into manageable pieces and to test specific components of the typology separately. Using a common framework

² G. Langley, et al., op. cit.

with a common language further facilitates the sharing of change concepts among health plans.

Step 1: Creating an Aim Statement

An Aim Statement provides a clear quantitative goal for the health plan’s quality improvement team. An effective Aim Statement is clear and specific and sets “stretch” goals, i.e., quantitative targets that are a real reach. The improvement team needs to establish an achievable Aim. However, if a plan reaches its Aim too quickly, it might be too low.

Principles of an Effective Aim Statement

- Define the population
- Define the time period
- Set the direction
- Set numerical goal
- Set “stretch” or ambitious goal

Examples of Aim Statements

“Identify 100 percent of health plan members, age two to 18 years, who had a diagnosis of asthma within the last year.”

“75 percent of children with special health care needs will have a medical home by the end of the project.”

Step 2: Developing Measures for Improvement

Many health plans fall short in measuring the effectiveness of their new approaches. Large amounts of data collected over long periods of time are rarely required to assess the impact of a change. Small repeated measurements collected over shorter periods of time – known as pilot (or process) measures – will enable the health plan to document progress toward the Aim, and will make clear whether the change is having the expected impact.

Developing Process Measures

- Seek usefulness, not perfection.
- Measure as often as possible.
- Measure at regular intervals.
- Include qualitative and quantitative measures, if necessary.
- Take a sample if using the total population delays measurement.

Linking Measures to Aims

Aim

Measure

<p>“Contact 90 percent of members who are pregnant prior to delivery.”</p>	<p>Numerator: Number of successful outreach attempts to pregnant members</p> <p>Denominator: Number of deliveries</p>
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BCAP TIP



Why Test a Change?

- Document magnitude of expected improvement.
- Evaluate “side effects” of change.
- Learn how to adapt the change to the local setting.
- Minimize resistance on full implementation.

Principles for Testing a Change

- Start small.
- Use volunteers.
- Don't worry about full buy-in.
- Plan multiple cycles to test and adapt the change.

Step 3: Identifying, Planning, and Testing a Change

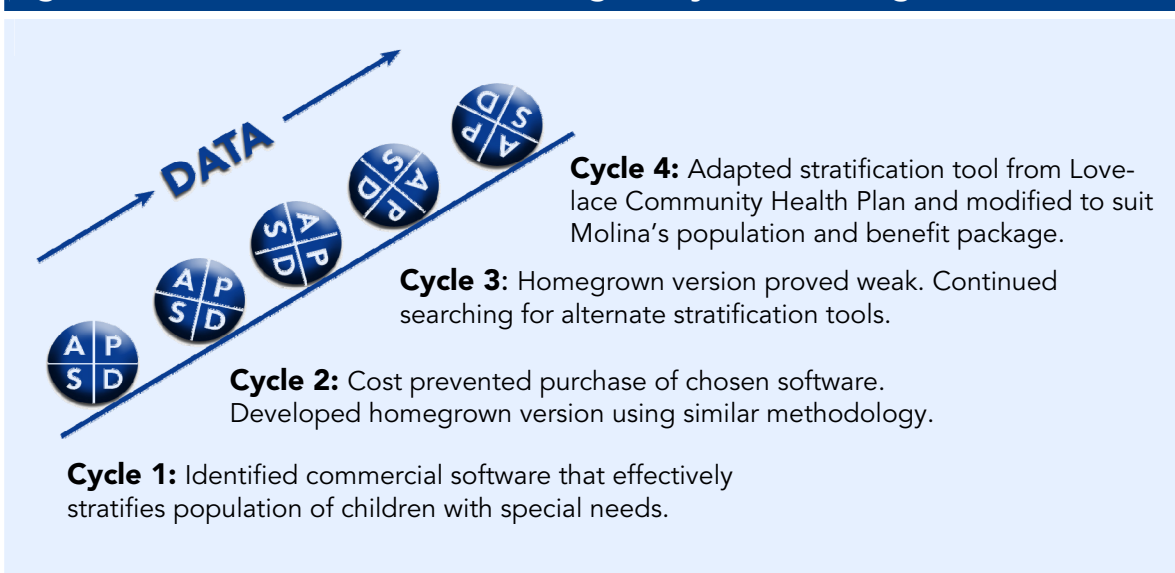
Each BCAP workgroup team should select process changes to be made based on the needs of its own organization. It should test selected changes on a small scale, review measures, make adjustments, and measure again. These cycles are repeated until the team is satisfied with the results.

When planning to test a change, project staff should understand their roles clearly. In addition, project staff should coordinate appropriate training and communication before “going live” with the change.

Figure 1 shows the PDSA cycles for stratification applied by Molina Healthcare of Washington in a BCAP workgroup, *Improving Care for Children with Special Needs*. Molina's Aim was to develop an optimal tool that would stratify 100 percent of the children with special needs into low, medium, and high risk. Molina started by testing small changes, monitoring them, evaluating outcomes, and then making the necessary modifications to meet its goal.

In using rapid cycle improvement strategies, it is critical that each cycle be clearly documented to help the project move forward and to prevent repetition of tactics that were already tried and discarded.

Figure 1: Molina Healthcare of Washington Cycles of Change: Stratification



Measurement and Evaluation

Demonstrating the success of any quality improvement initiative requires consistent and frequent data collection. Periodic measurement provides both a diary of where a quality improvement project has been and a roadmap for the future. Three categories of measurement are used in the BCAP Quality Framework to evaluate short- and long-term successes:

- **Pilot measures:** Describe individual improvement team results and reveal where changes are working and where adjustments are necessary.
- **Common measures:** Defined and approved by all BCAP participants within a project. The measures allow BCAP participants to compare their progress against their own or an aggregate baseline and create normative comparisons.
- **Capacity measures:** Examine team capabilities, organizational processes, and systems changes to sustain the best practice, as well as the team's success in spreading its innovation or best practice.

Establishing baseline data for each of these measures and collecting data at frequent intervals are critical to demonstrating the success of an initiative. CHCS provides each participating team with an evaluation workbook — the BCAP Quality Workbook. This workbook contains several linked spreadsheets that are completed at regular intervals by the participants. The spreadsheets reinforce rapid cycle improvement by providing places for an overall project plan, the documentation of the PDSA cycles, and regular collection of the measurements undertaken in each of the BCAP Typology categories. The workbook also contains scales to measure the team's function and success as well as their success in sustaining and diffusing their pilot project. Health plans report that the workbook allows them to keep all their documentation in one place so they can describe their activities, the barriers/opportunities they face, their stakeholders, and the process changes they are making. Linking project descriptions with measurement data help plans provide at-a-glance information to easily evaluate whether or not changes are successful.

Pilot Measures

Pilot measures are unique to each participating health plan. These measures are designed to support the plan's rapid cycle improvement

efforts and usually are process measures. Health plans design pilot measures for each component of the BCAP Typology. The plans are encouraged to choose process measures that are simple to collect and can be monitored as often as possible. Plans are encouraged to choose an outcome measure linked to the overall Aim of the pilot project.

Pilot measures should be collected monthly, if possible, to maintain the momentum of the project and to provide an evaluation of the pilot activity's progress. Whenever possible, participants should choose measures that are under the quality team's control, rather than having to wait through the typical administrative data lag.

Examples of pilot measures for asthma include:

- *Identification:* Increase the identification rate to 12 percent for Latino children, age 2-18 with asthma:

All Latino children, age 2-18, with asthma

All Latino children, age 2-18, who are members of the plan

- *Stratification:* Stratify 100 percent of the identified Latino children, age 2-18, with asthma into three categories – low, moderate, or high-risk asthma – based on numbers of canisters of rescue medication used:

All Latino children, age 2-18, with asthma stratified

All Latino children, age 2-18, with asthma

- *Outreach:* Invite 100 percent of the families of Latino children, age 2-18, with moderate or high-risk asthma to participate in a home environmental assessment:

All Latino children, age 2-18, who have moderate or high-risk asthma

All Latino children, age 2-18, with asthma stratified

All Latino children, age 2-18, with moderate or high-risk asthma

invited to participate in home environmental assessment

All Latino children, age 2-18, with moderate or high-risk asthma

- *Intervention:* Perform a home environmental assessment for 75 percent of Latino children, age 2-18, identified with moderate or high-risk asthma who were invited to participate:

All Latino children, age 2-18 with moderate or high-risk asthma,

who participated in home environmental assessment

All Latino children, age 2-18, with moderate or high-risk asthma invited to participate in home environmental assessment

The BCAP convener/faculty should help quality improvement teams design simple, useful, and easily collected pilot measures. To standardize and simplify reporting, participants should be encouraged to use the evaluation workbook.

The collection and analysis of pilot measures is conducted at the plan level, since few, if any, of these measures are comparable across workgroup teams. The emphasis is on monitoring the progress made through graphs and charts and on discussing the changes in the slope of the data trends. A simple graph is a powerful tool for quality improvement, particularly when the changes in slope are annotated with the interventions that were initiated at that point in time.

Common Measures

Participants in a BCAP workgroup agree to collect a common set of measures to reflect the progress of the initiative on a broader scale. Common measures are usually outcome measures and may include HEDIS[®] measures, as well as others that the workgroup develops and defines. The purpose of collecting common measures is not to compare participating health plans to each other, but rather to document how each team is improving from its own baseline and to evaluate the overall impact of the project.

For example, the 11 Medi-Cal health plans participating in the *California Asthma Collaborative* formed a data task force to create and define common measures. The plans agreed to collect and submit the following measures for each of four years:

- Members identified with asthma.
- Asthma-related hospital admissions and days per member (for the total plan membership and members with asthma).
- Asthma-related emergency department visits per member (for the total plan membership and members with asthma).
- HEDIS Appropriateness of Medication for People with Persistent Asthma.

Figure 2: California Asthma Collaborative Identification of Members with Asthma-All Ages

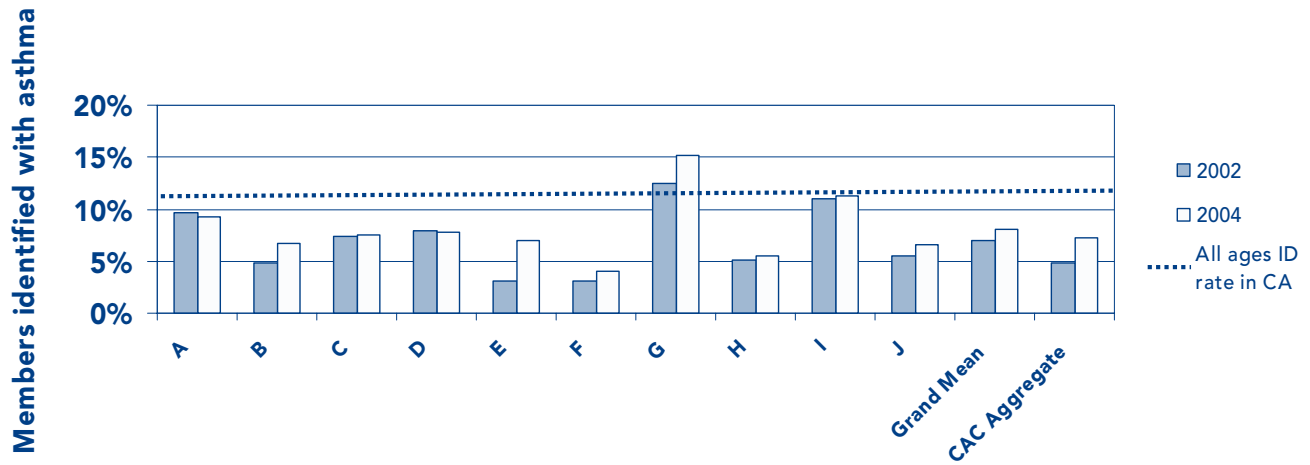
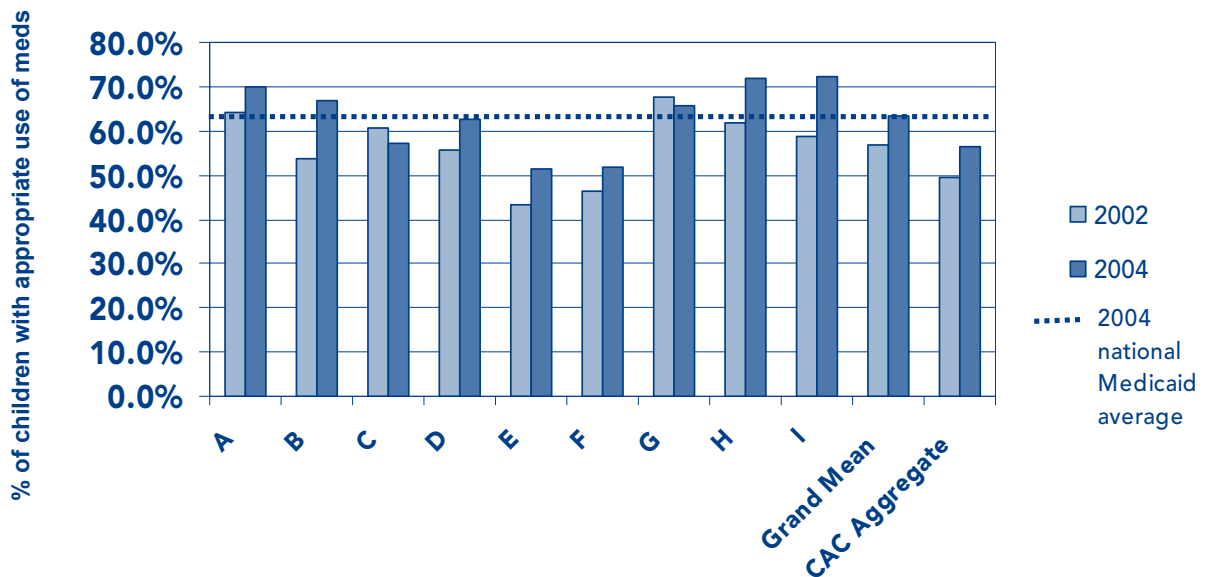


Figure 3: California Asthma Collaborative HEDIS: Appropriate Use of Medications Age 5-9, from 2002-2004



This is a significant accomplishment that allows for comparability across all teams on the common measures. The teams agreed to share their data (unblinded) among themselves and also (blinded) with plans in other states as well as in publications working with CHCS on improving care for people with asthma (see Figures 2 and 3).

The convener of the BCAP workgroup should devise a template for use by all of the plans to promote the submission of comparable data. Measures should be collected regularly (e.g., quarterly, semi-annually, or annually) to reduce the burden on the participating plans. For example, the *California Asthma Collaborative* collected common measures annually – for calendar years 2002, 2003, 2004, and 2005. This allowed for baseline data (2002) and three years of follow-up data. Because the common measures are defined the same for each plan, the data can be aggregated to provide the participants with a group comparison.

Capacity Measures

Capacity measures evaluate the quality improvement team's capabilities, organizational processes, and systems changes to sustain the best practice, as well as the team's success in spreading its innovation or best practice. These qualitative scales are collected at the same time as the pilot measures. They are designed to promote discussion within the quality improvement teams so that problems can be identified and addressed in a non-judgmental fashion. The capacity measures are:

- **Team Assessment Scale:** Allows the team to rank itself and measure the capacity and effectiveness of the team approach.
- **Sustainability Scale:** Examines long-term potential early in the process so the quality improvement team can plan for the institutionalization of new best practices.
- **Diffusion Scale:** Measures the team's success in spreading the best practices from its pilot projects to other quality improvement efforts within the health plan and to external audiences.

Sustainability and Diffusion

Sustainability

Sustainability means ensuring that the successful pilot activities are institutionalized and will continue after the improvement team has

been disbanded. This involves transitioning from a pilot project to a permanent way of operating – a clear measure of project success. A permanent change in structure, process, regulation, policy, or staffing can make the pilot project an enduring program strategy.

Identifying return on investment – economic, business, and social – is a key step to confirming the long-term viability of quality improvement approaches. Careful and strategic measurement of investments made, operational costs, and outcomes achieved (including costs avoided) contribute to a comprehensive analysis of return. The identification of return on investment and likelihood of sustainability are important questions for conveners to consider prior to beginning the project to determine if the project will be worthwhile, or another clinical topic should be chosen.

Diffusion

Diffusion is the spread of both the best practice, proven by the pilot project, and the application of the BCAP Quality Framework methodology to other quality improvement projects. Documenting the successes of a localized pilot project usually garners internal and external support to expand the project to reach broader target audiences. Many health plans that have participated in BCAP have adopted the BCAP model as the plan-wide approach for quality improvement for all clinical areas and populations.