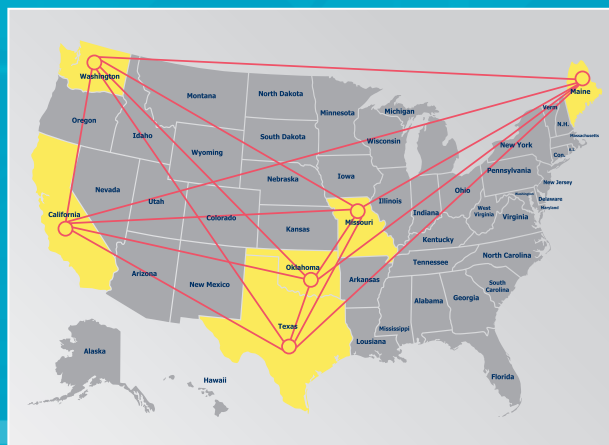


Implementing a State-Level Quality Improvement Collaborative:

A Resource Guide From the Medicaid Network for Evidence-based Treatment (MEDNET)



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Contract No. HS019937-01

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AHRQ Publication No. 14(15)-0064-EF
October 2014



Disclaimer of Conflict of Interest

None of the investigators has any affiliations or financial involvement that conflicts with the material presented in this report.

Funding Statement

This Guide is the product of the Rutgers University Institute for Health, Health Care Policy, and Aging Research's (IHHCPAR) Medicaid Network for Evidence-based Treatment (MEDNET). This project was funded under contract/grant number HS019937-01 from the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. The opinions expressed in this document are those of the authors and do not reflect the official position of AHRQ or the U.S. Department of Health and Human Services.

Acknowledgments

This Resource Guide is the product of multiple collaborative efforts.

First, the Rutgers University IHHCPAR Center for Education and Research on Therapeutics appreciates AHRQ's support of MEDNET. Specifically, we extend our gratitude to Dina Moss, our program officer, who envisioned the benefits of multistate collaboration and understood the challenges involved in bringing this work to fruition.

Most notably, the Guide would not have been possible without the unwavering 3-year commitment of the six MEDNET States: California, Maine, Missouri, Oklahoma, Texas, and Washington. Because the MEDNET State teams put into practice quality improvement strategies designed to increase the uptake of evidence-based clinical and delivery system practices in the provision of mental health treatment for Medicaid beneficiaries, we now better understand how health agency policy leaders can use data to inform health policy and improve care. The care of many Medicaid beneficiaries is now better as a result.

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Introduction

This Resource Guide (Guide) is a publication for State agencies and policymakers, as well as other stakeholders, interested in implementing a State-level quality improvement collaborative that addresses a specific clinical concern such as various mental health conditions that affect the Medicaid population. A quality improvement collaborative usually consists of policy leaders and health stakeholders working toward a common goal of improving performance on a well-defined quality measure or set of measures. The core components of a quality improvement collaborative, including the importance of collaborative learning and making policy decisions based on evidence and sound data, are outlined in this Guide and illustrated by examples from the Medicaid Network for Evidence-based Treatment (MEDNET).

Medicaid Network for Evidence-based Treatment (MEDNET)

The Guide is a product of MEDNET, a unique partnership between Rutgers and Columbia Universities, the Agency for Healthcare Research and Quality, AcademyHealth, and six State Medicaid/mental health policy collaboratives. This 3-year multistate consortium focused on increasing the use of evidence-based clinical and delivery system practices in the provision of mental health treatment for Medicaid beneficiaries. Specifically, the six participating States—California, Maine, Missouri, Oklahoma, Texas, and Washington—each implemented a quality improvement collaborative within their States that sought to accelerate the adoption of evidence-based practices (EBPs) to improve mental health outcomes.

MEDNET provided assistance to the State collaboratives and evaluated the strategies they used to increase the implementation of two types of comparative effectiveness findings in Medicaid mental health:

- Effective and safe clinical practices related to pharmacological and psychosocial mental health treatment; and
- Effective State policies, strategies, and organizational practices related to management of those treatments.

Benefits of Collaborative Work To Improve Performance

This Guide describes in detail how to engage leaders, stakeholders, and partners, as well as the tactics for convening them to allow for an exchange of information. Providing meaningful opportunities for decisionmakers to interact and exchange ideas with researchers and with their peers greatly accelerates this process of research and knowledge uptake and use.¹ Most collaboratives center on creating these kinds of exchange opportunities, although they vary based on the nature of the relationships being cultivated among members of the target audience and between the target audience and researchers.

Tactics used to facilitate that exchange of data and information will also vary based on the backgrounds and receptiveness of the audience. While webinars and written products such as issue briefs are appropriate for those requiring an introductory level of exposure to a topic, interactive learning, data analysis, and technical assistance are essential for those engaged in implementation. Dialogue and support among peers have been shown to be enormously important, not only in accelerating learning but also in sustaining motivation to participate in the

collaborative over time. Passive processes are recognized as ineffective while interactive engagement produces beneficial results.²

Necessity of Data To Drive Health System Transformations Through Collaboratives

It is important to emphasize the necessity of managing collaboratives and partnerships through data, not intuition or anecdote.

This Guide also focuses on how to use data to identify pertinent issues, develop an actionable quality improvement plan, and subsequently measure quality improvement. It is important to emphasize the necessity of managing collaboratives and partnerships through data, not intuition or anecdote.³ During the initial stage of a collaborative, data analysis should be used to identify the clinical concern and determine the specific problem of focus. Often, learning collaboratives are initiated to address a problem identified by stakeholders. However, a State also must be able to describe the problem that this potential collaborative will seek to address. While the problem may be apparent, understanding or describing the contributing factors and potential areas for improvement can be more challenging. Analysis of the problem often requires further research and investigation, so partnering with the academic community is useful.⁴

Once a specific area of focus has been determined, appropriate metrics that will track process or outcome changes need to be selected. The types of data available to the collaborative (for example, State administrative or patient-level clinical data) will help inform measurement strategies and metric development. Over the course of the collaborative intervention, data allow for an initial benchmark from which to measure improvement and provide an accurate story of the quality improvement collaborative.

Data are also powerful tools for engaging partners who will work with the collaborative to implement the identified quality improvement strategy. Sound data are more compelling to stakeholders and partners than anecdotal evidence. In addition, reliable data that are shared and discussed in an unbiased manner build trust between those participating in the collaborative.

Steps To Develop and Implement a Multistakeholder and Data-Driven Quality Improvement Initiative

This Guide outlines the steps necessary to develop and implement a multistakeholder and data-driven quality improvement initiative. Table 1 provides an overview of components needed to develop a quality collaborative and describes guiding questions for each step. Each of the steps below is informed by stakeholder feedback and the available evidence (data). While the steps seem to be in sequential order, many of the steps occur concurrently, particularly in the beginning phases of the collaborative.

Table 1. Steps to develop and implement a quality improvement collaborative

Steps	Guiding Questions
Identify the problem the collaborative seeks to address	<ul style="list-style-type: none"> • Is this problem a priority given the current policy environment? • How has this problem manifested in the past based on available data?

Steps	Guiding Questions
Recruit champions, project lead, and core team	<ul style="list-style-type: none"> • What is currently being done to address the problem? • Who is best positioned to be the champion of this collaborative? (See recommended qualifications in Table 2.) • Who has the clinical knowledge as well as leadership skill to serve as project lead? • What are the potential functions that the core team will need to perform?
Identify local experts and engage interested stakeholders and partners in the collaborative	<ul style="list-style-type: none"> • Who outside of the core team has an interest or stake in this issue? • Is the stakeholder group inclusive and representative of different perspectives? • How will the collaborative engage this stakeholder group? • What are the roles and responsibilities of the stakeholder group? • Which partners will participate in the core collaborative and actively work to improve quality?
Gather and distribute all existing information describing the problem (e.g., clinical and administrative data, case studies, promising practices, standard metrics if available)	<ul style="list-style-type: none"> • What does the current evidence suggest about factors contributing to the problem? • What does the evidence suggest for improvement targets? • What is unknown?
Develop quality improvement goals with defined and specific targets	<ul style="list-style-type: none"> • Propose a quality improvement plan. • Do these goals align with the identified problem? • What are the barriers to executing the improvement plan?
Develop quality improvement plan	<ul style="list-style-type: none"> • How will the collaborative execute on these goals? • What contributions are partners responsible for (i.e., need to establish expectations for participation)? • What is a reasonable timeline for implementing the intervention? • How will participants be recruited to participate in the intervention? How can the stakeholders be leveraged for this process?
Select and/or develop metrics and refine measurement strategy	<ul style="list-style-type: none"> • Are there any relevant metrics currently available or do new metrics need to be developed? • What is the denominator for the metrics (e.g., the population of interest)? • What are the inclusion criteria? • What data sources are required to populate the metrics? • Who will run the metric analyses? • How often should the metrics be run and reported to the group? • What results should be reported and how?
Oversee intervention and monitor/document progress	<ul style="list-style-type: none"> • What can be implemented to improve the quality of care? • What barriers or challenges have arisen when implementing the intervention? • How can the group work together to overcome these challenges?

Steps	Guiding Questions
	<ul style="list-style-type: none"> • Is the intervention proceeding in a timely manner? Does the timeline need to be adjusted? • How often should the collaborative meet to update the stakeholder group? • How should the progress be documented (e.g., milestone reports)? • What measures are being used to evaluate the intervention?
Disseminate results to the collaborative and beyond	<ul style="list-style-type: none"> • How do you engage partners regularly? • What are the target audiences for disseminating the results (e.g., policymakers, colleagues in State government, clinicians, researchers, and the public)? • What format should be used for the most impact (e.g., webinars, peer review publications, issue briefs)?
Plan for sustainability	<ul style="list-style-type: none"> • How can the interventions be leveraged, spread, or institutionalized? • Can the metrics be embedded in other efforts? • What stakeholders are interested in future collaborations? • How should the State leverage momentum from collaborative and harness for future efforts?
Select and/or develop metrics and refine measurement strategy	<ul style="list-style-type: none"> • Are there any relevant metrics currently available or do new metrics need to be developed? • What is the denominator for the metrics (e.g., the population of interest)? • What are the inclusion criteria? • What data sources are required to populate the metrics? • Who will run the metric analyses? • How often should the metrics be run and reported to the group? • What results should be reported and how?

How State Agencies and Stakeholders Can Use This Resource Guide

This Guide outlines the major components of a State-level quality improvement collaborative and the considerations necessary for implementation. It is meant to contribute to the efforts of State leaders who are interested in creating a stakeholder-informed process to address a specific clinical issue and facilitate the sharing of expertise and solutions.

As noted above, this Guide outlines the major components of a State-level quality improvement collaborative and the considerations necessary for implementation. It is meant to contribute to the efforts of State leaders across State agencies who are interested in creating a stakeholder-informed process to address a specific clinical issue and facilitate the sharing of expertise and solutions. States are already poised to be leaders in the area of quality improvement through their ability to determine a clinical or policy goal, collect data, report quality information, encourage best practices, and coordinate various stakeholders to support the creation of a broad-based quality improvement strategy. This Guide is meant to supplement those capabilities with specific considerations for building a collaborative.

The emphasis of this guide is on the importance and utility of such collaboratives to address Medicaid mental health, using examples from MEDNET State collaboratives. Medicaid mental health is a complex issue that tends to involve patients who have more than one medical condition (both physical and mental). In addition, in many States, multiple agencies (e.g., Medicaid, mental health departments, substance abuse agencies, pharmacy departments) play a role in delivering care to these individuals. Therefore, collaboratives provide an opportunity for various stakeholders (both internal and external to government) to develop a data-driven quality improvement plan as part of a joint effort to more effectively coordinate care for these patients. Collaboratives also are an ideal opportunity for peers from relevant agencies and organizations to convene and learn from each other while implementing the quality improvement plan's various components. While this Guide is applicable to all State leaders, agencies, and departments, primarily State Medicaid and mental health agencies will find it helpful for their purposes.

How the Resource Guide Is Organized

This Guide outlines the major components of a quality improvement collaborative that is developed once a clinical concern or problem is identified. It is divided into sections that can be read separately to assist those implementing various pieces of a quality improvement collaborative. While it lays out what should be decided or identified sequentially, once all the components are recognized, they can and often do occur simultaneously. The sections include:

1. Identify a Champion, Project Lead, and Core Staff Team.
 2. Engage Stakeholders and Partners.
 3. Ensure a Data-Driven Process.
 4. Develop a Data-Driven, Iterative, and Actionable Quality Improvement Plan.
 5. Implement Policy and Quality Interventions.
 6. Host Collaborative Activities.
 7. Disseminate.
- Bonus: Cross-State Collaboratives.

1. Identify a Champion, Project Lead, and Core Staff Team

Strong leadership at multiple levels is a critical element of successful quality improvement initiatives. Namely, having a skilled champion and project leads working together helps ensure that the project is strategically positioned for success and progresses in a timely manner.

The champions have the overall vision for the collaborative and can effectively articulate its process and outcome goals to various stakeholders, both inside and outside of government. The champion has ultimate accountability and authority for the quality improvement project. This individual should be a senior-level executive or agency head with significant experience leading quality improvement programs. For significant quality improvement efforts, the selection of an appropriate and effective champion is especially critical, as that individual's support of the effort raises its profile, and their contributions affect the overall success of the initiative. For Medicaid mental health collaboratives, the champion could be the Medicaid director, Medicaid medical director, or Medicaid mental health director. Table 2 describes several qualifications of a champion.^{5,6}

Table 2. Champion qualifications

Qualifications	Description
Position and visibility	The champion holds a senior-level position in the State government and has the authority to make critical decisions (e.g., resource allocation, data sharing). When senior-level individuals champion an initiative, they increase its importance throughout the organization and are more likely to win prompt support for necessary actions.
Access and relationships with key stakeholders, experts, and other partners	Through his/her current position and other experiences, the champion has a network of potential partners to engage in the initiative. Partnerships with key stakeholders, experts, and other partners add credibility to the initiative.
Personal commitment to the issue and ability to inspire others	When a champion has a demonstrated commitment to an issue and inspires enthusiasm in the issue from others, the initiative is more likely to succeed.
Experience with leading quality improvement programs	Experience with other quality improvement programs allows champions to know when to push forward and when to compromise on tough decisions. This experience will also contribute to the overall progress of the initiative.
Ability to identify, connect with, and leverage internal resources for this program	This ability, related to the champion's position, allows the quality improvement initiative to connect with other internal resources, which increases the capability and efficiency of the program.
Knowledge and awareness of context and external factors	Champions can successfully advise their team about potential pitfalls or barriers to implementation and how to navigate diverse stakeholder interests if they have sufficient knowledge about the context of the initiative.

A champion is not the only leader of a successful quality improvement initiative. Successful initiatives also need a hands-on project lead or manager working in tandem with the champion. This project lead manages the day-to-day processes of the initiative and has the content knowledge and managerial skills to keep the project steadily moving toward its target goals. In comparison, the champion is engaged and informed of the activities and can take the necessary steps when needed if momentum is faltering.

The list below describes several qualifications that should be considered when selecting a project lead:

- Decisionmaking authority.
- Deep content knowledge of the issue being addressed by the initiative.
- Ability to inspire stakeholder trust.
- Skills to facilitate effective group processes.
- Ability to reach closure on issues raised.
- Attention to detail and effective time management.

Without a strong project lead, the quality improvement initiative is less likely to adhere to the proposed timeline and will struggle to achieve its desired results within a tight project timeline. In addition, lack of operational leadership can result in disinterest from internal staff team members—as well as external stakeholders and partners—who are working to balance many competing priorities and projects.

Once a champion and project leads are identified, the next step is to recruit a core staff team. The members of the core team should be individuals who are integral to different parts of the project. For example, one of the core team members should be an experienced data analyst who is dedicated to running and managing all of the work on data. Other core team members could include clinic managers, community liaisons, and other content experts, based upon the chosen project focal point. For Medicaid mental health collaboratives, staff from relevant State agencies should participate, as well as community mental health directors. This team should meet on a regular basis with the project lead to share implementation updates, discuss any challenges, and brainstorm solutions. It is important to have these various roles filled to manage the collaborative in dynamic environments and ensure continuity when changes (e.g., changes in funding, staffing) occur. Once the champion, project lead, and core team have been assembled, the next step is to engage stakeholders and other partners.

Lessons From MEDNET: Missouri and Another MEDNET State

One example of an effective champion is Dr. Joe Parks from the Missouri MEDNET team, the chief clinical officer for the Missouri Department of Mental Health. Dr. Parks is a national and local clinical and policy expert in the field of public mental health. In his position as the chief clinical officer, Dr. Parks is able to encourage cross-agency cooperation and data-sharing agreements. The team credits Dr. Parks' leadership as one of the critical factors in their success.

In comparison, the experience of another MEDNET State illustrates how not having a champion for a project can adversely affect the implementation process. While their project lead was capable and dedicated to the project and the State was able to implement an intervention that had some early positive results, the team experienced challenges because the State agency director was not engaged in the project. Without adequate resources, limited technical and administrative support, and status within the Medicaid program the team lead had difficulty soliciting partners in other units in the State government. Without a bona fide champion—someone with decisionmaking power—the team experienced difficulties navigating interagency silos and lacked authority to make decisions. The lack of a champion constrained progress and affected the overall scope of the intervention design.

2. Engage Stakeholders and Partners

Simply put, collaboratives that engage relevant stakeholders in a meaningful way are more successful than initiatives that do not have stakeholder support. Engaging stakeholders early and often helps ensure that the initiative addresses an issue of importance to the broader community in an informed and effective way. Stakeholder input is extremely valuable to the development and implementation of an initiative, as their experiential knowledge can complement or inform the present evidence or data on an issue.

Meaningful stakeholder engagement during the design of an initiative increases the likelihood of their support during the implementation process, as their early, substantive involvement will create a sense of ownership over decisions made during the initial phases. In addition, stakeholder-informed policy decisionmaking has been gaining momentum nationally and is often a requirement of federally funded collaboratives based on its benefits. The following list is a summary of the potential benefits of stakeholder engagement:

- Develop quality improvement initiative that is more relevant to the public and more likely to be implemented and sustained.
- Improve selection and prioritization of targets.
- Improve management of funding and resources.
- Improve significance of outcome measures to the end user.
- Improve recruitment of participants.
- Help disseminate information about the intervention.⁷

The first step in convening a stakeholder group is to identify, recruit, and engage key stakeholders from a variety of backgrounds, organizations, and constituencies with relevant interest in the issue (e.g., stakeholders' interests are directly affected). Stakeholders are not limited to individuals who will be affected positively by the initiative, and a broad range of perspectives should be represented within the group. While maintaining diverse perspectives within the group should be a goal, it is also important to consider whether the group will still be productive, given the potentially large number of interested stakeholders. Thus, a balance between stakeholder inclusion and maintaining a functional stakeholder group size is ideal.

The stakeholder group should also be composed of partners involved in implementing the intervention and those who are not, but have relevant expertise. The six States participating in the MEDNET collaborative engaged multiple types of stakeholders and partners in their interventions. As this collaborative focused on data-driven improvement of pharmacological and psychosocial mental health treatment, as well as implementing State policies, strategies, and practices related to these issues, relevant stakeholders and partners included academic institutions, clinicians and community mental health centers/clinics, patients and consumers, and interagency colleagues.

Examples of each type are found in Table 3.

Table 3. Stakeholders and partners engaged in MEDNET

Stakeholder/Partner Type	MEDNET Example
Academic and community partners	The Maine and Oklahoma MEDNET initiatives partnered with academic centers to assist with the data analysis and development of the metric reports. Additionally, the university-affiliated academic centers provided information about the scope of the problem and assisted in developing the goals of the initiative. Furthermore, the Maine team engaged an outside community foundation, the Maine Health Access Foundation, to support their clinic collaborative.
Community mental health centers/clinics, clinicians, managed care organizations (MCOs)	Representatives from community mental health centers (including clinicians and clinic operations staff) participated as members of the Washington and California MEDNET stakeholder groups. These stakeholders provided critical feedback on the implementation of the intervention in the clinics and how to recruit clinicians to attend continuing medical education courses and participate in academic detailing. In addition, Texas engaged the MCOs and their medical directors in their stakeholder group to identify metrics and inform clinician feedback reports.
Patients and consumers	California and Maine stakeholder groups included consumer representatives who provided feedback on consumer education brochures and academic detailing materials.
Interagency stakeholders	All of the MEDNET States engaged interagency stakeholders within their State governments. These interagency stakeholders included representatives from State mental health and substance abuse services divisions, State Medicaid agencies and their drug utilization review (DUR) boards, and departments of aging and child and family protection services. For example, the Missouri team engaged representatives from the Department of Mental Health (DMH), the Department of Social Services (DSS), community mental health clinics (CMHCs), and community advocates. Oklahoma worked closely with an established relationship between the College of Pharmacy and the Medicaid DUR. These partnerships broadened the perspective of the project, with subcommittees on measure selection and report updates, and provided more opportunities for sustainability.

Lessons From MEDNET: California, Oklahoma, and Texas

MEDNET States shared several strategies and best practices for stakeholder engagement. The States recommended leveraging existing relationships with stakeholders, learning collaboratives, and internal advisory boards as a sounding board for recruiting additional stakeholders for the MEDNET project. For example, Texas engaged their managed care organizations' (MCOs) medical directors and external quality review organization (EQRO) in MEDNET activities after their transition to a primarily Medicaid managed care system. This provided a great opportunity to include MEDNET metrics in their EQRO's quality review process, the results of which are ultimately shared with the MCO medical directors. In addition, as risk, performance, and quality accountability shifted to the MCOs, an audience and infrastructure to address prescribing practices was established. In Texas, the trend to carve into the Medicaid MCOs' responsibility for mental health services continues to expand and the EQRO and the MCOs are collaborating on improving antipsychotic medication prescribing practices across multiple populations.

California also engaged a diverse group of stakeholders. Since the California team was based in a Medicaid managed care program (CalOptima), the team was able to engage mental health consumers and clinicians in the CalOptima system while developing informational materials that encouraged patient empowerment, positive provider relationships, and safe antipsychotic medication use. The team credited the success of these efforts to the guidance received from consumers and clinician stakeholders. The brochure was developed and translated into multiple languages and distributed to both primary care and specialty practices in the CalOptima network.

While Texas and California successfully engaged stakeholders from the inception of their MEDNET projects, Oklahoma provides an example of how stakeholder involvement can shape and expand an intervention after it has launched. In its initial phase, the Oklahoma team engaged the State Medicaid drug utilization review (DUR) board to successfully launch its enhanced DUR intervention. MEDNET champions were engaged through an existing advisory stakeholder group, the State Behavioral Health Advisory Council (BHAC). This group convened monthly and expanded the reach of MEDNET to include the statewide group of community mental health center directors. In the second half of the MEDNET project, the Oklahoma team formed a strong partnership with the Oklahoma Department of Mental Health and Substance Abuse Services that exponentially increased the opportunities and sustainability of their intervention. Oklahoma stands as an important example of how bridging the divide between State agencies can be an important sustainability strategy. It is critical to remain alert to engaging new stakeholder relationships as projects evolve.

In summary, the MEDNET States recommend frequent contact with active stakeholders to keep them informed of the ongoing work and to solicit feedback through regular meetings and calls. As mentioned, Oklahoma held monthly calls with a small cohort of active members of the BHAC to query them for feedback on the enhanced letters that had been mailed—including their preferred format and data visualization mechanisms, share the responses to those letters, and solicit potential areas of focus for future mailings. Information sharing was leveraged as a strategy for engaging stakeholders and partners working with the collaborative to plan and implement the quality improvement strategy. Finally, States emphasized that responsiveness to the feedback from stakeholder groups was critical as it built trust and ultimately improved the intervention.

3. Ensure a Data-Driven Process

Data and information sharing are the most important components of a quality improvement collaborative, not only because they are necessary to identify the issue and measure progress, but also because they provide evidence that the stakeholders and partners can react to and address. Because they are an integral part of a collaborative, there are many considerations when selecting appropriate metrics and conducting analyses, including data sources, measure testing, and ways to present the results to various users. Some high-level considerations include:

- **Selecting Measurement Concepts:** This process is important because it helps to ensure an accurate understanding of the clinical issue at hand and to identify how to intervene. Meaningful stakeholder participation in the selection process enhances their commitment to the quality improvement intervention and helps to identify measures that align most closely with the priority data needs around the selected clinical issue. Criteria for deciding which measures to use should include⁸:
 - Extent to which the measure is actionable.
 - Magnitude of burden imposed by the clinical condition.
 - Extent of gap between current practices and evidence-based practices for a clinical condition and the likelihood that the gap can be closed.
 - Relevance to a broad range of individuals.
 - Extent to which the quality measure has either been developed or accepted, or approved through a national consensus effort.
 - Degree of variation across clinicians.
 - Extent to which the quality measure is valid and reliable.

- **Identifying Data Sources:** In order to present stakeholders and the quality improvement initiative participants with a complete picture of the issue they are working to address, multiple data sources may need to be consulted. On a subject such as pharmacological and psychosocial mental health treatment, these could include Medicaid claims and eligibility data, pharmacy claims, child welfare databases, and clinical and hospital discharge data. Questions to consider when deciding how to use data include:
 - How important are the data?
 - What do the data represent?
 - How helpful are the data?
 - How can the data be acquired?⁹

- **Executing Business and Data Use Agreements:** Acquiring needed data can be difficult, particularly if the data streams are separated. Difficulties are due to issues related to data access, interagency rules about data sharing, and incompatibility of health information technology systems. In some cases, memorandums of understanding (MOUs), business agreements, and data use agreements need to be signed in order to exchange data between agencies. It should be noted that this can be a time-consuming process, although well worth the effort to provide the richest understanding of system processes and patient outcomes. Generally speaking, these types of agreements govern who owns the data, what purposes they can be used for, who from each participating agency will have access

to the data, whether data will be at the aggregate level or at the patient level (and if at the individual level, what patient identifiers will be allowed), and what measures will be taken to ensure the security of the data before, during, and after their transfer.⁸

- **Developing Measure Specifications:** Evidence-based measures that are standardized and endorsed nationally are always preferable if they meet the needs of the project. Unfortunately, previously endorsed quality measures can often be inadequate for a specific project's needs, meaning that customized metrics must be developed. A systematic review of the evidence and guidelines for best practices is required to develop specifications. A major consideration when developing the measures is the denominator; inclusion criteria could include a specific population (e.g., low-income individuals, adults), types of providers (e.g., public hospitals), and/or different funding streams (e.g., Medicaid). MEDNET developed Medicaid-based measures for States to use on topics such as adherence to medication, polypharmacy, and diagnosis consistent with receipt of medication.
- **Testing the Measures:** Testing is required to make sure metrics are reliable and valid. Does the indicator measure the issue, i.e., is an accurate picture of the problem being captured? Testing can be done with a sample of the State's data or with a sample from national datasets. For example, MEDNET tested their measures using 2003-2004 Medicaid Analytic Extract (MAX) data for 45 States.
- **Collecting, Integrating, and Analyzing Data:** Below are considerations for data collection, integration, and analysis.^{8,10} A schematic used regularly by MEDNET of the multiple data sources and users of those data can also be found in Appendix 1.¹¹
 - Medicaid administrative data is a critical resource for States.
 - Data collection and data linking may need modification to be customized for a specific circumstance.
 - If multiple data sources are necessary to calculate the measures, they must be integrated and matched using patient and physician identifiers.
 - Data also should be compiled and analyzed by one central organization, whether it be a data analyst within the State or an academic partner (which may also require identifying avenues for data flow, creating trusted data repositories, and signing data use agreements).
 - Compromises are inevitable and must be identified, noted, and resolved, including some related to data quality and completeness and whether results will be comparable for benchmarking. According to a MEDNET webinar presenter from Minnesota, risk adjustment is also "important when comparing different providers' performance on an outcome-oriented measure, especially in context of multipayer initiatives and public reporting, [but] there are tradeoffs between administrative burden imposed by collecting more data for the adjustment and employing a more sophisticated methodology."⁸
 - Analysis should also be doublechecked and reviewed by a subset of the audience to ensure it is correct. For example, before any broader reporting of any analysis is undertaken, the participants who submitted their data should be given an opportunity to review the analysis for verification of results, including an opportunity to ask questions about the methodology if needed.

- **Reporting Results:** The findings of the analysis should be shared with the stakeholder group and other partners at baseline and periodically thereafter to determine what interventions should be implemented or changed. The initial report will not only help flag the quality concern, but will also be the starting point on which to measure progress during the course of the intervention. Depending on the audience for the report, it could be shared in different formats with different comparators and at different time intervals.^{10,12}
 - **Format:** In Washington State, the clinics involved in the intervention appreciated receiving the reports in Excel spreadsheets so they could reorganize and customize the output themselves. For busy physicians or policymakers, making the information easy to understand is important, whether via graphics, tables, progress over time, or geographic mapping. There should also be considerations about how much detail to include about the data or whether summarizing them with composite measures is sufficient for the audience.
 - **Comparators:** Many reports also include comparators to help clinicians benchmark their practice to others and create goals. Benchmarks can include the local and national averages and the average of peers (whether the units of analysis are clinics or individual clinician types). In addition, they can be categorized by the “best” quintile and the “worst” quintile.
 - **Reporting Frequency:** It can be difficult to identify the optimal timing for report dissemination, as there is a tension between providing the latest data as soon as they have been submitted and analyzed and allowing enough time for the intervention to have a possible impact on the data. Repeated measurement and reporting are critical to understanding the quality improvement intervention. In this way, strengths and weaknesses are revealed, and adjustments/improvements to the initiative are made.
 - **Method:** Consider how the feedback reports are delivered to the target audience and via what modality. For example, should they be shared through a private Web portal or mailed? Also, should they be mailed to the clinic directors to review with the staff or directly to the clinician?

Note: A sample clinician feedback report can be found in Appendix 2.

- **Conducting an Evaluation:** An evaluation of the collaborative’s work should be undertaken to assess the value of the strategy and intervention activities at both the process and outcome levels. This is an essential task if the goal is to sustain and leverage these efforts. Consider having an external, unbiased organization perform the evaluation. The evaluation could include both qualitative and quantitative analysis. For example, Texas, Oklahoma, and Maine engaged universities to collect their State data and analyze them using specified measures. Because the Texas Medicaid population is almost entirely covered by medical managed care organizations, they used their EQRO to evaluate their collaborative work using MEDNET metrics. Oklahoma enhanced their DUR activities, directed by the College of Pharmacy, to provide an iterative evaluation and feedback process. In addition, MEDNET collected information about States’ outreach efforts quarterly to assess whether they were making an impact. Appendix 3 is a tracking sheet States were asked to complete, with items such as “Date list of flagged patients was sent to clinic/providers” and “Date trends in project metrics are shared with stakeholders.”

4. Develop a Data-Driven, Iterative, and Actionable Quality Improvement Plan

After identifying the project’s goal, team, data sources, and measures, it is critical to document the plan in writing. Developing a quality improvement plan will help break the process down into actionable steps, track outcomes, and identify areas for improvement. This section contains a step-by-step model for creating a quality improvement plan, key questions to ask when developing the project, and examples from MEDNET.

The Plan-Do-Study-Act (PDSA) Model

The PDSA method, developed by the Institute for Healthcare Improvement (IHI), is a four-step guide for establishing a continual quality improvement project plan (see Figure 1). The method, described below, along with the MEDNET Quality Improvement Plan Outline (see Appendix 4) and lessons learned, can serve as a guide for agencies and individuals embarking on quality improvement projects.

Plan: Set the goals of the quality improvement cycle—questions, predictions, data to be collected—and the who, what, when, and where of the project. Table 4 outlines key questions.

Do: Carry out the plan and document problems and unexpected observations.

Study: Complete the analysis of the data, compare to predictions, and summarize lessons.

Act: Determine changes to be made and decide what will happen in the next cycle.

Figure 1. Quality improvement cycle¹³

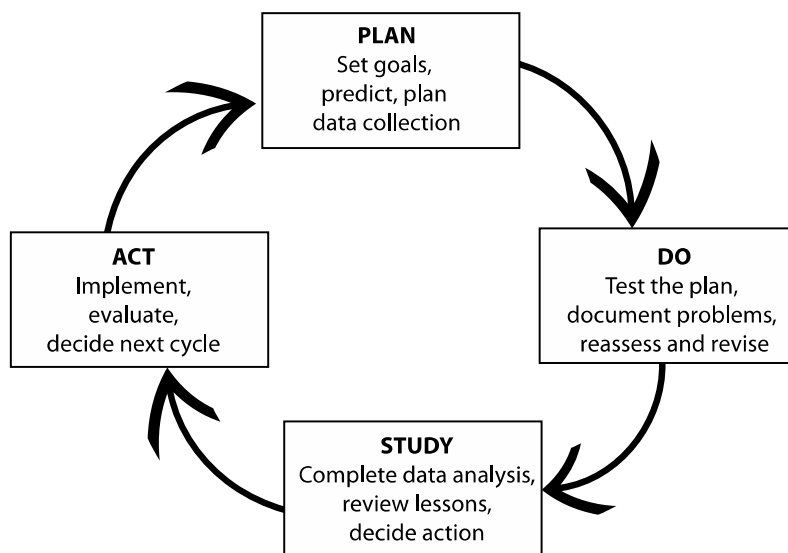


Table 4. Quality improvement plan building questions

1. What is the desired outcome/overall goal of the project?
2. Who is the target population? a. Demographic/diagnostic groups b. Treatment settings c. Geographic areas d. Clinician types e. Other
3. What is the target level of change desired? a. Patient v. clinician level
4. What intervention will the project employ?
5. How does the intervention align with existing State infrastructure? Examples include: a. Specific policies b. Data collection structures and data sharing agreements in place c. Contracts with partners d. Incentives
6. Where does infrastructure need to be developed to successfully execute the intervention?
7. What data does the intervention require? a. Are these data available in existing datasets? b. Does the State need to create data sharing agreements?
8. What is the intervention timeline? a. Is the project feasible within the allotted timeframe?
9. Should the intervention be scaled up or down based on the questions above?
10. How will the State monitor the project's progress?
11. What obstacles does the State foresee?
12. How will the project overcome these obstacles?

Lessons From MEDNET: Missouri

Missouri implemented a highly successful quality improvement plan to continuously improve prescribing practices and, therefore, the quality of care provided to patients who were taking antipsychotic medications but were not eligible for Missouri's Health Home Initiative.

Missouri targeted both patients and their prescribers. On the patient side, the Missouri plan focused on all Medicaid beneficiaries (adults and children) with severe mental illness (SMI) and serious emotional disorders (SED). On the clinician side, it targeted clinicians who met outlier prescribing criteria and specific prescription counts. The intervention involved sending quarterly feedback reports to clinicians who prescribed medications that were flagged as outliers by adherence, dose, safety, and polypharmacy metrics. These reports also included information on general utilization measures, caseload severity, and cost. In addition, ad hoc reports based on areas of interest expressed by their stakeholders were created, including one on opioid prescribing patterns.

Missouri located the MEDNET intervention in an established behavioral pharmacy management (BPM) program subcontracted to run regular pharmaceutical reports. As such, the project had access to datasets, clinician-level reports, and mailings, as well as data analysts from the outset. By working with an established program, the State was able to leverage goals and reduce startup time. The Missouri MEDNET team developed a plan to improve the BPM program's measurement strategies and report formats. The stakeholder group that convened over the course of the 3-year project prioritized core measures and reinvigorated the reports. Using existing infrastructures or initiatives can have a positive impact on the early stages of the quality improvement initiative, allowing a faster "launch" and avoiding redundancy.

While Missouri's MEDNET project was able to show improvements on many metrics, they struggled to reduce opioid polypharmacy and improve opioid prescription practices. In response, Missouri is implementing a second opinion program to address antipsychotic medication polypharmacy and other clinical edits, including those related to opioid prescribing.

5. Implement Policy and Quality Interventions

In addition to mounting a multistakeholder quality collaborative as Missouri did (described at the end of the previous section), States can implement various other policies and administrative practices to support quality improvements. These policies and practices are generally implemented in tandem with collaborative activities and are integral to supporting practice improvements. Descriptions of possible interventions and their strategic categories can be found in Table 5.^{13,14}

Table 5. Possible quality improvement interventions

Intervention	Description	MEDNET Example
Policy/System		
Hard Pharmaceutical Edits and Prior Authorizations	Payers implement hard edit requirements and prior authorizations before a service is provided to ensure that they are medically necessary to consumers.	In June 2011, Texas Medicaid implemented a prior authorization for antipsychotic medications. It requires that clinicians answer the following questions: <ol style="list-style-type: none"> 1. Is the client under the age of 3? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Go to #2) 2. Does the client have 2 active claims for different antipsychotic agents (Hierarchical Ingredient Code List, HICL) in the last 180 days, excluding the incoming request? <input type="checkbox"/> Yes (Go to #3) <input type="checkbox"/> No (Approve – 365 days) 3. Does the client have 1 active claim for an antipsychotic agent (HICL) in the last 30 days, excluding the incoming request? <input type="checkbox"/> Yes (Deny) <input type="checkbox"/> No (Approve – 365 days)¹⁵
Leverage Performance and Quality-Based Contracting	Payers provide incentives to providers/clinicians who perform well and sanctions to providers/clinicians who perform poorly, i.e., pay for performance (P4P). Requires States to think about “value-based purchasing strategies” and is especially suited to managed care environments.	With the transition from fee for service to almost entirely managed care, Texas Medicaid is considering adding quality standards to their managed care organization contracts.
Second Opinions/ Consultations	Mandatory second opinion programs have been used since the early 1980s to improve care, monitor service utilization, and provide safety consultations to clinicians before care is rendered. States can implement a range of approaches, from specific requirements or laws to consultation help lines.	Washington State contracts with the University of Washington to run a mandatory second opinion program and Partnership Access Line (PAL). ¹⁶ PAL is a telephone-based child mental health consultation system for primary care clinicians. PAL is funded by the State legislature and employs child psychiatrists and social workers affiliated with Seattle Children’s Hospital to deliver its consultation services.

Intervention	Description	MEDNET Example
Policy/System		
Lock-In Programs	Lock-in programs restrict patients to a single pharmacy, hospital, or health care setting. They are designed to assist efforts by health care providers/clinicians to monitor potential abuse or inappropriate utilization of medical services.	Oklahoma has a pharmacy lock-in program in which certain SoonerCare members are required to fill all prescriptions at a single designated pharmacy in order to better manage their medication use.
Disease Registries	Registries provide a monitoring system where all clinically related information is input and then used for understanding and addressing quality issues.	While not a MEDNET State, North Carolina did share information about its “Keeping It Documented for Safety” Registry. On this registry, clinicians document the use of antipsychotic medication therapy in children and adolescents. The registry tracks diagnosis, height, weight, symptoms, psychosocial treatments, adverse events, metabolic monitoring, and parent choice. ¹⁷
Education/Outreach		
Patient Activation Strategies	Patient activation strategies promote participation in the patient’s own care, while positively affecting patient-centered communications and patient perceptions of engagement in care.	Patient involvement in treatment decisionmaking is associated with improved adherence for some drugs. Other examples are: <ul style="list-style-type: none"> • Enhanced self-management abilities • Shared decisionmaking • Wellness coaches • Smart phone applications • Consumer Web portals
Quality Improvement Tool Development	Tools can take on various forms to further promote the intervention. They can include toolkits for implementing quality interventions; guidelines outlining best practices; dissemination materials, such as brochures, to promote engagement; etc.	California developed cardiometabolic risk brochures in various languages ¹⁸ to explain to consumers the potential cardiometabolic side effects of using certain mental health medications. Maine also developed a Wellness and Recovery Toolkit ¹⁹ to help mental health agencies integrate overall health and wellness into their service settings.
Academic Detailing	Academic detailing involves outreach and face-to-face education of clinicians by trained health care professionals around how best to treat specific medical conditions consistent with medical evidence.	The Maine legislature authorized the Maine Department of Health and Human Services Office of Medicaid Services to create an academic detailing program—Maine Independent Clinical Information Service (MICIS). The first detailing topic concerned the initiation of insulin for Type 2 diabetes, the evidence for use of multiple oral agents, and the role of diabetes education in management. A second topic concerned antiplatelet agents: when, which one, how much. ²⁰

Lessons From MEDNET: Maine

Since the Maine Medicaid program implemented robust prior-authorization policies beginning in 2003, the Maine MEDNET team considered creative ways to align activities with existing efforts in the State to maximize the efficiency and impact of the State Medicaid quality improvement program. As a result, the team leveraged partnerships with other data-driven quality improvement initiatives both within the Medicaid agency and the Office of Substance Abuse and Mental Health Services and successfully recommended integrating the MEDNET metrics into biannual health quality reports for the Medicaid program and other reports for the State's Patient-Centered Medical Homes and CMHC-based Health Homes initiatives. This integration enabled the metrics to be standardized across agencies and populations, as well as regularly reported.

In addition, the State AHRQ Multiple Chronic Conditions project focused on beneficiaries with severe mental illness and other medical comorbid conditions. This work examined the impact of cardiometabolic risk in this group and used MEDNET metrics to track the rates of metabolic monitoring among this group. This work has important policy implications in Maine; diabetes screening and prevention became a priority addressed in the medical home projects in the State. Therefore, Maine serves as a useful example that not every quality improvement program needs to be created as a new standalone project and demonstrates how considerations of the State context, priorities, and existing relevant programmatic efforts are important in maximizing potential impact.

6. Host Collaborative Activities

Regular communication among all participants in a collaborative is key to its success. MEDNET State partners noted that the opportunity to network and share knowledge with peers and across silos and agencies was one of its most valuable components. This section of the Guide provides instruction for multiple interactive collaborative and technical assistance activities.

Kickoff Meeting

When launching a quality improvement initiative, it is helpful to gather the champion, project lead, core team, stakeholder group, and partners in a kickoff meeting. In many cases, the kickoff meeting will be the first time that everyone engaged in the initiative will spend time together in an in-person setting. It is an opportunity to bring together multiple perspectives to brainstorm ideas, further design a quality improvement plan, and strategize about future activities and next steps. As one of the first opportunities for face-to-face interactions between the members of an initiative, the success of this meeting can set the tone for the rest of the initiative and provide an opportunity to generate interest and forward momentum.

The project lead and core team must carefully plan and prepare for the kickoff meeting with input and guidance from the project champion throughout the planning process. As with every meeting, there are both content-related and logistical considerations. Below are steps for developing the event description and agenda content.

The description should reflect:

- Why this issue is of importance in both the State and national contexts.
- The host organization and other partners.
- High-level summary of the concept for the proposed initiative.

General kickoff meeting agenda topics:

- Welcome, introductions, and agenda review.
- Setting the stage (i.e., at the national and State level) and describing the issue to be addressed by the quality improvement initiative.
- Overview of the quality improvement initiative:
 - Presentations from experts in this field or others who have done similar work.
 - Discussion about how the proposed quality improvement initiative aligns with other State-led efforts or opportunities.
- Working sessions to provide feedback on the quality improvement plan (see Section 5).
- Working sessions focused on different products (e.g., data report format, metrics used).

Other suggestions:

- Use input from “meeting advisors” (e.g., early stakeholders) who can provide feedback on the meeting’s content and agenda.

- Be sure to include adequate time for discussion and Q&A. Often, the most valuable contributions of these meetings are the lessons learned and ideas generated from discussion among all participants.
- Consider the timing and flow of the meeting and include adequate time for breaks.

For a checklist and timeline of meeting planning activities, see Appendix 5.

Ongoing Quality Collaborative Meetings and Activities

Ongoing meetings help the collaborative assess needs, provide technical assistance, and determine the trajectory of the project. Both in-person meetings and teleconferences can be used for these purposes.

Monthly Conference Calls

In the beginning phases of the collaborative, frequent meetings are necessary to plan the intervention and discuss logistical concerns. They also play an important role in maintaining early momentum among stakeholders. It is important to ensure that representatives from all participating agencies can attend. These meetings should be held at least every other week during the early months of the project. Topics to address initially include the following:

- Roles and responsibilities of participants.
- Logistics of the monthly calls, including dates and times for group calls, lead person to send reminders and agendas before the call and moderate the calls.
- Contact information for all participants, including that of their assistants.
- Project quality improvement plan (discussed in Section 5 of this Guide), if necessary. Based on the quality improvement plan, identify data and resource needs and strategies to address these needs moving forward.
- Subworkgroups, if necessary, to discuss niche issues such as data analysis, metric creation, and specific populations within the larger project. Identify a time for these workgroups to meet separately from the larger group.

Prior to the calls, the call lead should send reminder e-mails and agendas, and collect and distribute all relevant materials.

Once a plan is in place, States can transition to monthly calls, which will allow participants to check in with one another about the status of the project. On these calls, participants should discuss progress made, identify technical assistance needs, share information and lessons learned, and address any concerns they have or barriers they have faced. It is important to make sure that call participants have the authority to make decisions or direct access to those who can.

Prior to the monthly calls, participants should update their quality improvement plans and address the following four questions:

1. Describe the latest progress you or your agency/State has made in carrying out project goals over the last month.

2. Since the last monthly update, has your State encountered anything unanticipated, or has something significantly changed from what is outlined in your current action plan? If so, please describe.
3. What has your team been challenged by since the last monthly update? Were these challenges anticipated? Has your team successfully addressed the challenges, or are you still working through how to do so?
4. Has your team identified any new technical assistance needs? Please describe.

The call lead should compile key ideas and discussion points from participants’ responses and use this information to create an agenda for the call. The agenda must be sent to participants prior to the call. It is also helpful to select a participant on the call to take notes, create minutes that can be distributed and archived for review and process evaluation later, and write down action items to send to all members shortly after the call. These action items should be used to provide one-on-one assistance between calls and be revisited during the next month’s call to assess progress.

Face-to-Face Meetings

Followup in-person meetings provide the core team an opportunity to convene and discuss overall progress, questions, and resource needs that have arisen since the project kickoff, as well as lessons learned. Evidence from both the MEDNET project and the literature reveals that the “capacity to convene various stakeholders in the health care system can set the stage for a comprehensive approach” that might not otherwise be achieved.¹⁰ Compared to phone calls and webinars, in-person meetings allow maximum spontaneous sharing and back and forth with experts.

This section of the Guide addresses important considerations and steps to take when planning followup in-person meetings. Focused and clear content must be emphasized in planning face-to-face meetings. (For logistical information on meeting planning, the timeline outlined in Appendix 5 can be used.)

These meetings are a time for participants to:

- Share progress and engage in peer-to-peer learning with project participants.
- Share challenges and strategies taken to overcome them.
- Review data.
- Bring in experts to provide additional trainings, conduct exercises to address challenges, and give presentations on topics related to the meeting theme.
- Consider changes in the quality collaborative or improvement plan to increase impact.

Table 6 outlines key steps to take in order to host a successful meeting.

Table 6. Key steps for hosting a successful meeting

Task	Remember To Take Into Account...
Identify a theme for the meeting	The theme should reflect: <ul style="list-style-type: none"> • Feedback received from participants throughout the project via monthly quality improvement updates or calls. • A topic or challenge participants have encountered.

Task	Remember To Take Into Account...
	<ul style="list-style-type: none"> • An area where participants need more information or expert guidance.
Develop an agenda for the meeting	Designate time for experts to give presentations to the project team and for participants to discuss their progress with one another. Often, the most valuable takeaways from these meetings are the lessons learned and ideas generated from discussion with peers.
Identify expert speakers to address the meeting theme	<p>These experts may come from:</p> <ul style="list-style-type: none"> • Academic institutions. <ul style="list-style-type: none"> ○ Conduct literature scans based on the theme to see if authors of papers or professors may be appropriate speakers to address the theme of the meeting. • Government agencies (appropriate agencies should be identified based on the quality improvement initiative area of focus; in this example, they are agencies working on mental health). <ul style="list-style-type: none"> ○ State agencies such as the department of health, Medicaid agencies, and mental health agencies. ○ Federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), and Substance Abuse and Mental Health Services Administration (SAMHSA). Data experts often exist within government agencies but can also be found in academic institutions and other private sector agencies. • Peers. <ul style="list-style-type: none"> ○ Participants may benefit from hearing from others on the project who have had a lot of success or have overcome challenges. • Other States. <ul style="list-style-type: none"> ○ Often, other States may be tackling similar topics and issues. It may help to ask representatives from those States to talk about successful initiatives they are implementing. ○ Organizations that work with State officials, such as AcademyHealth, the National Academy for State Health Policy (NASHP), and the National Governors Association (NGA), may know which States have similar initiatives.
Ask participants to update their quality improvement plans prior to the meeting and prepare progress report presentations	These documents can help participants prepare for the meeting and guide the discussion. The staff organizing the meeting can ask for these updates in advance and use them to create the agenda.
Develop meeting materials and compile into a binder or folder to be given to participants	Agenda, session descriptions, participant progress report template, speaker and participant bios and contact information, copies of slide presentations, meeting evaluation, table tents, and name tags.

Webinars

A webinar is a convenient medium to convene participants and virtually provide technical assistance, seminars, and panels on topics of interest. The logistical and technical aspects of hosting a webinar are listed below. The sections above on kickoff meetings and in-person meetings can be used to aid in presenter and content selection when planning webinars and other educational activities.

Key Questions To Address During Webinar Planning:

1. What is the objective of the webinar? What need will it address?
2. Who is the intended audience?
3. What is the desired outcome?

Logistical Questions To Address:

1. What webinar platform will you use?
2. Will you need someone from the webinar platform company to serve as moderator? If so, does your selected vendor provide such a service?
3. Do you need to reserve the time in advance?
4. Does the platform have a participant capacity limit and will you exceed it? Typically, about 50 percent of invitees that RSVP “yes” actually attend the webinar.
5. Will you need to include closed captioning or recording during the event or a transcript postevent? Will the selected vendor be able to offer these services or will you need to contract with an additional service provider?

Tips for Presentation Length:

- Webinars with one presenter should be no longer than 1 hour in total. Reserve 15 to 20 minutes for moderated audience questions and answers during or at the end of the presentation.
- Webinars with multiple presenters should not exceed 90 minutes. Reserve 15 to 20 minutes for moderated audience questions and answers during or at the end of each of the presentations or at the end of all presentations.
- Presenters should adhere to the rule of one slide per minute. A 20-minute presentation should contain no more than 20 slides.

See Appendix 6 for a checklist and timeline for planning webinars.

Collaborative Web Site

Creating a password-protected Web site for members of the collaborative is an easy way to disseminate information and encourage communication among participants throughout the course of the project. Below is a description of useful features to include when creating a project Web site.

1. **The Home Page:** The home page should display announcements, a calendar of upcoming events, a to-do list for members, and a section highlighting the latest resources or other features on the Web site.
2. **Documents Section:** This page should be easily accessible and allow members to both upload documents they want to share with colleagues and download documents that others have posted. Documents may include call agendas, meeting notes and materials, webinar recordings, quality improvement plans, articles, etc. To organize this page, it is helpful to include a feature that allows members to sort these documents into folders and subfolders.

3. **Web Forum:** This serves as the group’s online discussion forum. Members can post questions, themes, or concerns and get feedback from other members on topics raised. Members are able to respond to all posts. This is one of the easiest and timeliest ways for members to engage in peer-to-peer learning and access real-time information to aid in decisionmaking.
4. **Contact List:** The contact list should include the names of all collaborative members and their e-mail addresses and phone numbers (the Web site is password protected so security should not be an issue, but States may want to give members the option of not including contact information on the Web site).
5. **Links:** This page will provide links to resources that both staff and members of the collaborative can access.

Lessons from MEDNET: Washington

Washington State used a collaborative approach as part of its State MEDNET intervention. The State partnered with the Washington Community Mental Health Council to create the Medication Practice Improvement Collaborative (MPIC). This learning collaborative consisted of two cohorts of six community mental health agencies. The clinics met in person three times over the course of the project and participated in teleconferences and technical assistance webinars. Participants in the MPIC built on the lessons learned from these other efforts and benefited from clinical skill building for medication practice improvement through training, monthly learning collaborative sessions, and expert faculty. MPIC pilot sites led the State in effectively addressing critical issues for all community mental health agencies (CMHAs) and those they serve.

In the Washington MPIC learning community—which met in person three times during the 18-month life of the project—a kickoff meeting introduced participants to the learning community concept and provided a first opportunity for training in prescribing and adherence practice improvement strategies. It was also the first time clinics saw their benchmark reports and learned how to use them for quality improvement.

Washington’s MPIC held two in-person meetings after their kickoff meeting. The first was held halfway through the project to allow more indepth sharing of lessons learned and intensive training on key topics identified with feedback from the participants. The final in-person meeting was held at the project’s end, providing clinics an opportunity to reflect on the successes and challenges of the group’s work and to identify next steps. Each in-person meeting lasted 1 day.

In Washington, learning community members participated in 90-minute monthly webinars in addition to the in-person meetings. During the webinars, distinguished faculty composed of State and national leaders in the field provided training on relevant topics, and participants had the opportunity to talk with their colleagues at the other participating clinic sites regarding their progress and challenges.

7. Disseminate

Disseminating the information gathered and work products developed from a quality improvement initiative is an important way to expand the reach of the initiative, increase awareness of an issue, and sustain momentum of ongoing work and progress. Dissemination is not a passive activity. Rather, successful dissemination relies on actively targeting the right audience, breaking through the multitude of competing priorities and information sources, and offering practical, actionable information that can be used to improve on the current issue.²¹ Accordingly, the collaborative should develop a plan so the dissemination is strategic and efficient.

When developing a dissemination plan, the following themes and questions in Table 7 should be addressed.²²

Table 7. Items to consider when developing a dissemination plan

Items To Consider	Guiding Questions
Research evidence, project findings, and products	What is going to be disseminated?
End users (target audience)	Who can apply the information? What is their current knowledge of the issue? At what level of detail will they digest and use the information?
Dissemination partners	Through which stakeholders—individuals, organizations, or networks—can you reach end users?
Communication	How can you convey the outcomes of the initiative?
Evaluation	How can you determine what worked?

Given the large amount of information that quality improvement initiatives can potentially generate, it is important to consider what should be disseminated, as different end users may be interested in different aspects of the findings. Often, the outcomes and findings of quality improvement initiatives are of interest to multiple audiences and messaging should vary depending on the audience. Also consider: (a) the strength of the findings; (b) if the results can be generalized to other settings or populations; and finally, (c) what information is ready for broad dissemination.

The stakeholder group engaged in the initiative is an extremely valuable resource when considering dissemination strategies and should serve as dissemination partners and envoys of information. The core quality improvement group provides feedback on the messaging to the audiences they represent. In addition, the stakeholder group may have dissemination mechanisms/channels of their own to leverage for greater reach.

Once the target audience and the content are determined, the next planning step is determining how the information is presented and the language used in the messages. Different formats (e.g., press release, issue brief, peer-reviewed publications, brochures, webinars) should be considered based on the target audience. As mentioned previously, stakeholder input is useful in all aspects of planning dissemination.

The final step in the dissemination plan is evaluating the success of the efforts. To evaluate the success of dissemination efforts, the collaborative should monitor and track where the

information is shared and the approximate reach of these mechanisms (e.g., number of clinicians receiving a toolkit).²³

Lessons From MEDNET

For the MEDNET collaboration, information was disseminated in a variety of ways:

- Publications (e.g., peer-reviewed articles, issue briefs).
- Webinars on particular topics and sharing of information on technical assistance.
- Resource guides.
- Sharing results and data with academic centers for further analysis.
- Brochures for patients and consumers.
- Continuing medical education courses for clinicians.

Bonus: Cross-State Collaboratives

The defining feature of the MEDNET Multi-State Learning Collaborative was the inclusion of six innovative States eager to promote data-driven quality improvement activities designed to accelerate the adoption of evidence-based clinical practices for optimal psychopharmacological treatment in mental health care. While sections of the Guide provide specific examples of State-level quality improvement collaborative strategies, the implementation activities are easily adapted to multistate collaboratives leveraging the focused and collective power of peer-to-peer support.

Multistate, multistakeholder improvement projects are learning laboratories that more broadly share activities to support data-informed policy improvements. MEDNET participants benefited from lessons learned by all the States in the collaborative through regularly convened calls, educational and technical assistance webinars, and in-person meetings designed to foster many opportunities to learn from colleagues in other State environments. For example, testing the MEDNET metrics in the context of the multistate collaborative provided an array of opportunities for the participant States, including: benchmarking measurements across States; understanding metric utility for tracking improvements; identifying individuals or vulnerable subpopulations at risk; creating robust strategies for provider engagement; and implementing administrative policies to support optimal prescribing.

MEDNET participants reported that links to colleagues in other States were a highlight of the collaborative, essentially increasing the field of possibilities, experience, and wisdom. As States face new Federal and State requirements to monitor antipsychotic medication prescribing practices for children and adults, effective use of standardized quality measurement holds great promise of improved outcomes for public mental health systems. Multistate, stakeholder-informed, learning collaboratives are a key resource for health system transformation and improved health outcomes.

“Without the MEDNET support, inter-state collaborations would not have been possible. It is easier to make a case for change when you have the experience of other states to lean on. We will continue to consult with other MEDNET state partners long after the project ends.”

—Sosunmolu Shoyinka, M.D., Missouri

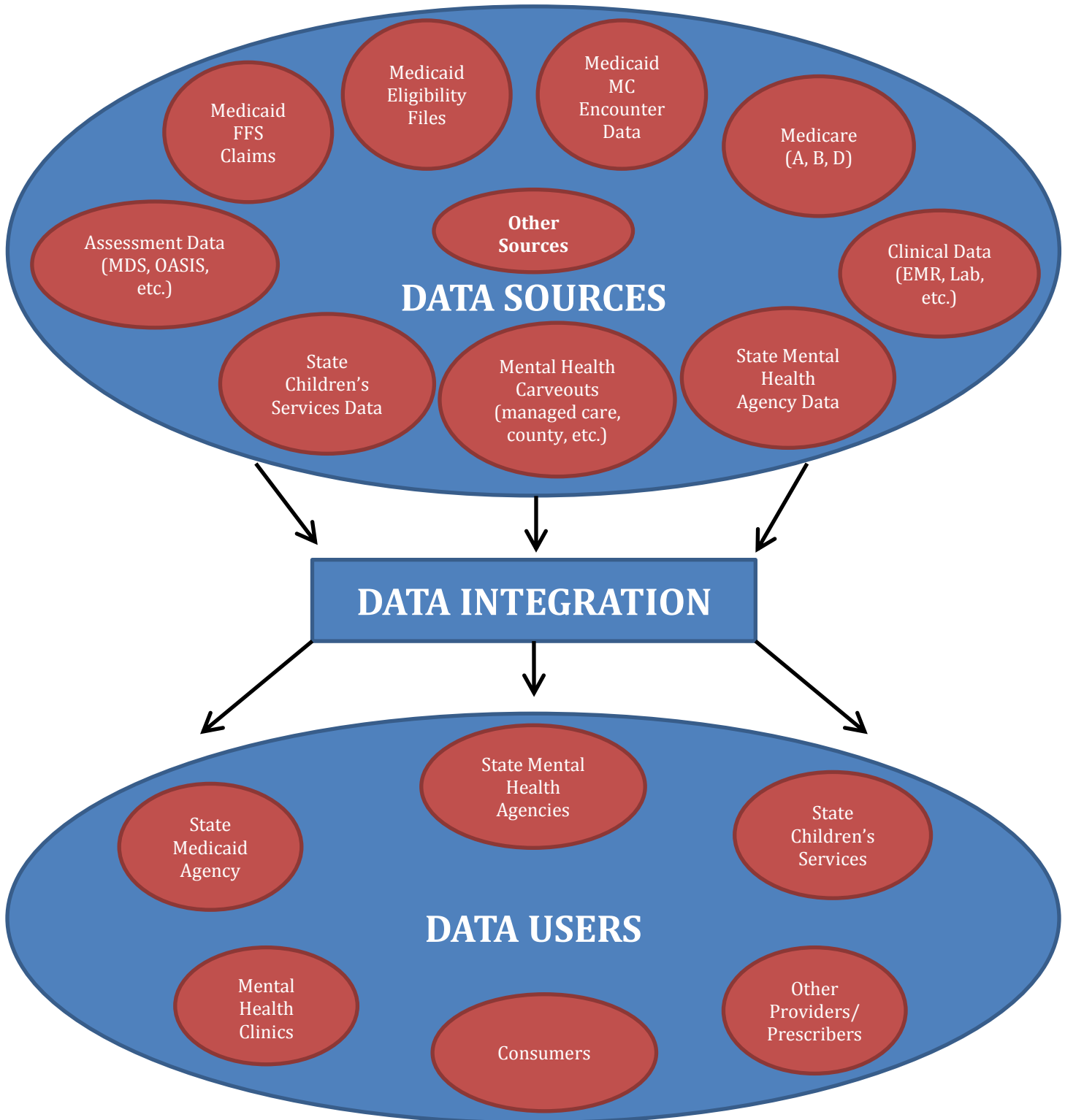
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- https://www.caloptima.org/en/~media/Files/CalOptimaOrg/HealthEducationMaterials/A-G/CardioMetabolicRisk_July12_F.ashx (Farsi);
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Appendix 1. Data Sources, Data Integration, and Data Users



Antipsychotic Medication Report

Report for 6-month period ending: June 30, 2011

Smith, John Q

Credentials: MD

CLINIC 999 2 ST

SEATTLE, WA 99999

Prescriber and Patient Summary

Your Prescribing

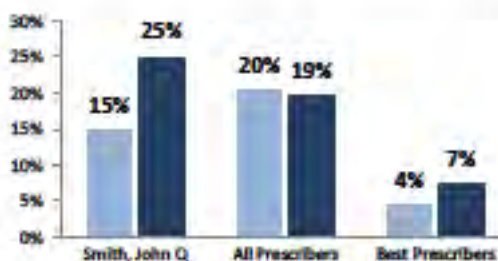
	Dec-10 Prior Period	Jun-11 Current Period	12/10-6/11 Change
Patients receiving antipsychotic (AP) meds attributed to you	34	32	-2
Antipsychotics filled in period prescribed by you for these patients	399	208	-191
Total cost of antipsychotics prescribed by you for these patients	\$107,249.92	\$115,185.60	\$7,935.68

Patient Risk Profile

	Your Patients Prior Period	Your Patients Current Period	All Patients Current Period
Percent of patients attributed to you with substance use disorder flag in admin data	32%	28%	23%
Percent of patients attributed to you with housing instability flag in admin data	12%	3%	11%

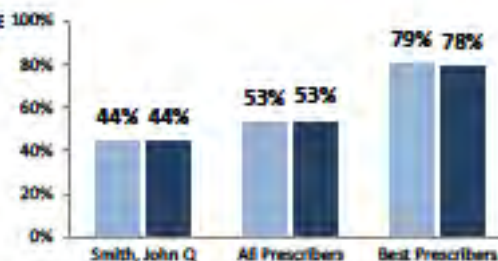
Percent of patients with current AP medication gap greater than 7 days

	Dec-10	Jun-11	Change 12/10-6/11
Smith, John Q	15%	25%	10%
All Prescribers	20%	19%	-1%
Best Prescribers	4%	7%	3%



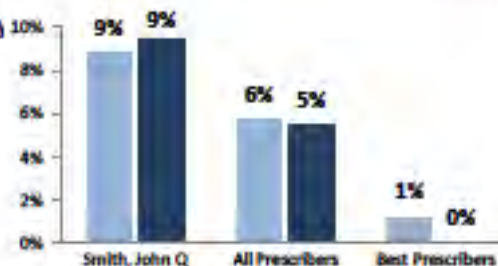
Percent of patients with AP medication possession ratio of 90% or above

	Dec-10	Jun-11	Change 12/10-6/11
Smith, John Q	44%	44%	0%
All Prescribers	53%	53%	0%
Best Prescribers	79%	78%	-1%



Percent of patients receiving AP med dose above FDA max in past 90 day

	Dec-10	Jun-11	Change 12/10-6/11
Smith, John Q	9%	9%	1%
All Prescribers	6%	5%	0%
Best Prescribers	1%	0%	-1%



DATA SOURCE: ProviderOne Operational Data Store

DATA DEFINITIONS: Patients receiving antipsychotic medication are attributed to the provider who wrote the most Medicaid-paid prescriptions for them in the reporting period. In the event of a tie, the patient is attributed to their most recent prescriber. Antipsychotic medications include conventional and atypical types. Measures are calculated over the portion of the 6-month reporting period where the patient was eligible for Medicaid, excluding time spent in a nursing facility, a medical or psychiatric hospital, or a state mental hospital. "Current gap" and "Medication Possession Ratio" measures are based on antipsychotic medication availability as determined by medication fill dates and the associated days supplied. Quality indicators are based on patients meeting the following criteria: (1) age 18-64 as of the end of the reporting period, (2) enrolled in SSI-related Medicaid coverage and not dually eligible for Medicare, (3) diagnosed with psychotic or mania/bipolar disorder in past two years, and (4) received antipsychotic medication in the reporting period. "Best prescriber" level is the 90th percentile among the 100 prescribers with the largest number of patients attributed to them.

Appendix 3. State Quality Improvement Implementation Tracking

STATE: DATE:

Measure	Definition	Instructions	Activation	Effectiveness	Sustainability	Target/Baseline	Result
State QI Collaborative established and implemented (Y/N)		Indicate completion date by state.					
Kickoff and booster trainings for clinics/providers convened (Y/N)		Indicate completion date by state.					
Clinics/providers submit QI plan (Y/N)		Indicate completion date by state.					
List of flagged patients sent to clinic/providers (Y/N)		Indicate completion date by state.					
Technical assistance provided to clinics/providers (Y/N)		List type of TA provided and mode (webinar, phone, email) by state.					
Systematic provider feedback strategies are developed (Y/N)		Indicate completion date by state.					

Measure	Definition	Instructions	Activation	Effectiveness	Sustainability	Target/Baseline	Result
Run chart data reflecting QI measures (# of flagged clients; # of clinical reviews conducted; # of flagged clients who no longer meet criteria)		Indicate metrics and summary of review flags.					
QI Collaboratives within states using CQI principles and strategies are developed (Y/N)		Indicate completion date by state.					
CQI process is instituted (Y/N)		Indicate progress/ completion by state.					
Trends in project metrics are monitored over time (Y/N)	By individual states	Indicate completion date by state.					
Trends in project metrics are shared with stakeholders (Y/N)	Individual state data	Indicate completion date by state.					
MEDNET State collaborative activities are documented (Y/N)	Implementation data collected.	Quarterly reports to Rutgers.					
State QI activities are documented (Y/N)	Implementation data collected.	Quarterly reports to Rutgers.					

Measure	Definition	Instructions	Activation	Effectiveness	Sustainability	Target/Baseline	Result
Clinics/providers report on QI activities (Y/N)		Indicate completion date by state.					
State QI activities and outcomes are shared through MEDNET and state collaborative (Y/N)	State spotlights on Web site, webinars	Indicate completion date by state.					

Appendix 4. MEDNET Quality Improvement Plan Outline

1. Infrastructure
 - a. Project lead
 - b. Point person for data analysis
 - c. Core staff team
 - d. Stakeholders
 - e. Partners
2. Data Considerations
 - a. Data sources
 - b. Metrics
 - c. Clinic/provider-level reports
 - i. Content and format of reports
 - ii. Frequency of reports
 - iii. Dissemination method
3. Target Population
 - a. Target demographic/diagnostic group
 - b. All or select treatment settings
 - c. Regional or statewide
4. Intervention Strategies
 - a. Quality collaborative
 - b. Clinic based
 - c. Policy based
 - d. Marketing/education
 - e. Other interventions
5. Collaborative Activities
 - a. Kickoff meeting
 - b. In-person meetings
 - c. Web-based materials
 - d. Consumer education materials
 - e. Technical assistance webinars
6. Dissemination Plan
7. Target Level of Change
8. Alignment of Policies, Contracts, Incentives
9. Timeline
10. Monitoring of Progress and Evaluation Plan

Appendix 5. Checklist and Timeline for Planning Meetings

8-12 weeks before event

- Identify meeting planning team and define responsibilities
- Assemble “meeting advisors” (e.g., early stakeholders) who can provide feedback on the meeting’s content and agenda
- Choose meeting time and reserve location
- Develop timeline of planning activities
- Develop general description of meeting (e.g., meeting purpose, focus, and early planning ideas)

5-8 weeks before event

- Hold planning call with core team (including leads) and “meeting advisors” to discuss agenda content and timing—See *Content Planning* for more information)
- Identify and invite participants (i.e., stakeholders and other experts)—See Section 4 for identifying stakeholders
- Invite and confirm presenters for any specific agenda topic
- Convene planning call with presenters to clarify any questions about agenda content and purpose
- Set deadline for presenter(s) to submit slides for review. *Tip: Generally, 2 weeks before the event, to allow time for an iterative review process between internal staff and presenters.*

4 weeks before event

- Finalize agenda and send to staff and presenters
- Collect biosketches from presenters

2 weeks before event

- Send reminder e-mails to invited participants for RSVPs
- Develop participant list
- Collect slides from presenter(s) and solicit feedback from staff. If necessary, send feedback to presenter(s) to update slides.
- Have staff edit slides—Spell out acronyms, check for font/size/formatting consistency, add page numbers

1 week before event

- Create meeting materials (e.g., binder with agenda, slides, participant list, presenter bios)
- Send reminder about meeting with updated agenda and logistics

Day before event

- Send final reminder to participants

Postevent

- Develop and share postevent report with participants. This report summarizes the content of the presentations, discussion/question and answer session, postmeeting feedback, and participant list.

Appendix 6. Checklist and Timeline for Planning Webinars

5-8 weeks before event

- Identify and confirm presenter(s) and moderator
- Identify and confirm participating staff members—*It is helpful to include staff to help speakers shape their presentations and shed light on the interests of the audience*
- Identify a staff lead to serve as contact person on webinar mailings
- Schedule event, planning call, and dry run and send calendar appointments to presenter(s) and staff

5 weeks before event

- Hold planning call with presenter(s) and staff to discuss content. *Send an agenda before the planning call.*
 - Discuss presentation length (see tips for presentation length below)
 - Discuss Q+A format and whether participant phone lines are open or muted throughout presentation. *This generally varies depending on number of attendees and presenter preference.*
- Set deadline for presenter(s) to submit slides for review. *Tip: Generally, 2 weeks before the event, to allow time for an iterative review process between internal staff and presenters.*

4 weeks before event

- Develop webinar agenda and description of event and send to staff and presenters
- Collect biosketches from presenters
- For a **closed webinar**, send calendar appointment with event description and login instructions
- For an **open webinar**, broadly circulate dissemination language to all potential interested parties, including a registration link. Once they have registered, a calendar invite will be sent to their e-mail address.

2 weeks before event

- Send reminder e-mails to invited participants
- Collect slides from presenter(s) and solicit feedback from staff. If necessary, send feedback to presenter(s).
- Have staff edit slides—Spell out acronyms, check for font/size/formatting consistency, add page numbers

1 week before event

- Create title and introduction slides and compile with presenter slides
- Upload compiled slides to webinar platform
- Develop staff script for event
- Hold dry run with presenter(s) and staff to review webinar technology, test audio, and answer questions

Day of event

- Log on 30 minutes prior to event and upload final presenter slides
- Upload slides in PDF format for participants to download if applicable
- Record presentation if applicable
- Poll members about satisfaction at end of webinar

Postevent

- Post recording (and transcript, if required) to Web site and/or e-mail to all invitees
- Develop postevent report summarizing the content of the presentation, question and answer session, post-webinar feedback, and participant list

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