

Improving Processes and Increasing Efficiency: The Case for States Participating in a Process Improvement Collaborative

MOTIVATION AND PURPOSE

State Medicaid and State Children’s Health Insurance Program (SCHIP) agencies provide vital health coverage to low income populations and other groups, but have limited administrative resources to support enrollment and renewal functions for these programs. Streamlining and enhancing the effectiveness of their administrative procedures and processes can help state programs do more with less and can ease the burden on individuals who apply to these programs by clarifying instructions or allowing phone or Internet applications or renewals. In short, everyone could benefit from improved procedures.

In this brief, we look at the experience that some state Medicaid and SCHIP agencies have had in using a process change model developed by the Institute for Healthcare Improvement (IHI), and adapted by the Southern Institute on Children and Families (Southern Institute), to strengthen the way they approach enrollment and retention administrative processes. IHI’s model, known as the Breakthrough Series, has helped numerous health care providers improve quality and efficiency in various ways, including reducing patient waiting times by 50 percent, reducing intensive care unit costs by 25 percent and reducing hospitalizations for patients with congestive heart failure by 50 percent (Institute for Healthcare Improvement, 2003). The Breakthrough Series uses a “process improvement collaborative” or “learning collaborative.” It has not been widely applied to improve purchaser administration. In this brief we explore whether state governments can use this model to improve Medicaid and SCHIP eligibility and enrollment processes and also whether a process improvement collaborative is a worthwhile investment for states.

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THE PROCESS IMPROVEMENT COLLABORATIVE IN COVERING KIDS & FAMILIES: A CASE STUDY

The IHI Breakthrough Series uses a process improvement collaborative to improve organizations by validating and accelerating improvements in processes (Institute for Healthcare Improvement, 2003). A process improvement collaborative has four key components:

1. Selecting a topic for improvement and identifying subject matter experts who can coach collaborative teams;
2. Inviting teams to apply for inclusion in the collaborative;
3. Offering three learning sessions, which are face-to-face meetings in which the participating teams and experts gather to learn and share ideas; and
4. After each learning session, applying what was learned to the team's work environment (Institute for Healthcare Improvement, 2003).

Teams are taught to use the rapid cycle Plan-Do-Study-Act (PDSA) model of testing changes: the team plans a process change, implements the change on a small scale, observes the measurable results and acts on what is learned, either by starting another PDSA cycle or adopting successful processes into widespread practice (Institute for Healthcare Improvement, 2003).

Based on engineering principles and implemented in the health care delivery sector, IHI's model has been adapted to other environments. For example, the Southern Institute, a nonprofit organization that works to improve the lives of children and families, adapted IHI's model to improve administrative procedures in a program intended to improve eligibility services in Food Stamps, Medicaid and SCHIP. Building on that experience, the Southern Institute administered two process improvement collaborative cycles in the Robert Wood Johnson Foundation-sponsored program, the Covering Kids & Families (CKF) program, which is the focus of the work we discuss here.

CKF is an RWJF-funded initiative to reduce the number of eligible but uninsured children and adults through increased enrollment and retention in Medicaid and SCHIP programs (Covering Kids & Families, 2007). RWJF funded CKF grantees in 46 states for four years.¹ Each grantee had to develop and work with a coalition, using outreach, simplification and coordination strategies to improve Medicaid and SCHIP enrollment and retention.

Process improvement collaboratives were not an original design component of CKF. However, shortly after CKF was implemented in 2002, an economic downturn led to increasing barriers for CKF grantees: states began scaling back coverage expansions, eliminating outreach and making other cost reductions in their Medicaid and SCHIP programs. Up to this point, CKF grantees and their coalitions had primarily focused on outreach, along with simplification of the enrollment process, for example shortened application forms and reduced verification requirements, as the methods of increasing Medicaid and SCHIP enrollment. These were useful strategies, but they were in direct opposition to changed goals in many states. CKF grantees needed other strategies for engaging state officials and maintaining CKF goals that would not simply increase state costs. Recognizing that a process improvement collaborative could achieve this, RWJF and the Southern Institute introduced the collaborative into CKF to help grantees execute simplification and coordination strategies aimed at enrollment and reenrollment processes.

The two CKF process improvement collaboratives followed the IHI model (attending learning sessions, using the PDSA model to test process changes and evaluate results, etc.). The goal of both Southern Institute-administered CKF collaboratives was to improve the efficiency and effectiveness of the Medicaid and /or SCHIP enrollment and retention processes. Medicaid or SCHIP officials from 21 states agreed to participate, or permitted their state and local staff to participate, forming teams with CKF grantees in their respective states. Fourteen teams participated in each collaborative with some teams participating in both (see Table 1). Teams generally had four or five core team members who attended the learning sessions. The core team included participants such as a Medicaid or SCHIP official, the state CKF grantee project director, a Medicaid or SCHIP field worker and a Medicaid or SCHIP field worker supervisor. In addition, teams often included non-traveling members, such as eligibility workers, clerical staff and others who have a role in the eligibility processes. These individuals were involved in testing and analyzing ideas.

TABLE 1

States Participating in CKF Collaboratives

State	Process Improvement Collaborative 1	Process Improvement Collaborative 2
Alaska	x	
Arkansas	x	
Florida		x
Georgia	x	
Hawaii	x	
Idaho	x	x
Illinois	x	x
Iowa	x	x
Louisiana		x
Minnesota	x	
Mississippi		x
Nebraska		x
New Hampshire		x
Ohio		x
Oklahoma	x	x
Oregon	x	x
Pennsylvania	x	x
Utah		x
Washington	x	
West Virginia	x	
Wyoming	x	x
Total	14	14

Source: CKF Process Improvement Collaborative learning session binders.

EVALUATING OUTCOMES

To determine whether state governments can use the process improvement collaborative model to improve Medicaid and SCHIP administrative processes, we closely studied a subset of CKF collaborative teams that either were deemed to have succeeded or were deemed to have been unsuccessful (see next paragraph for definitions). Work included observation at three of the six process improvement collaborative learning sessions (one in the first CKF collaborative and two in the second); review of collaborative training manuals and other methods of instruction; discussions with Southern Institute staff who administered the collaboratives; structured telephone interviews with six participants deemed successful and four deemed less successful by Southern

Institute staff; and a one-day evaluation meeting with seven teams deemed successful by Southern Institute staff (Vicki Grant, personal communication, May 9, 2006). We also reviewed literature on process improvement collaborative outcomes.

Evaluators defined a successful team as one that was actively engaged in and understood the PDSA process. Of the 13 teams interviewed, nine successful teams tested process changes, collected data and interpreted findings and identified positive (and negative) process changes. These teams understood the importance of spreading positive changes past the initial test site, and either expanded the process change to other sites or were working to do so.³

Each of the four less successful teams we interviewed had at least one of the characteristics that Ovretveit et al. (2002) identified as interfering with a collaborative's success. They include:

1. Having improvement topics that are too broad or unspecific;
2. A lack of clear team objectives or measurable targets;
3. Poorly formed, unprepared and/or unmotivated teams;
4. An inability to collect and analyze data;
5. Unclear roles and expectations among individual participants; and
6. Too much teaching and not enough "mutual learning" at learning sessions.

For example, one team had trouble collecting and analyzing data. In another state, the team was poorly formed, and lacked leadership and state support. For a third state, the team was poorly formed, and team members' roles and expectations were unclear. A fourth team also was poorly formed, experienced turnover among team members and did not have enough resources to support the team in its efforts.

KEY FINDINGS

In states with committed leadership and the ability to devote the resources needed to support it, a process improvement collaborative is an effective model for changing Medicaid and SCHIP enrollment and retention processes rapidly and sustaining improved processes (see insert below). Successful CKF collaborative teams learned methods and approaches that improved processes in the short run and led to positive changes in the philosophy and culture of state administration in the long run. Moreover, in successful states, the process improvement collaborative improved state program administration in ways that most likely would not have occurred without it. Some of the changes clearly improved efficiency and conserved resources. Some teams also reported increases in enrollment or retention rates, although we have not tested these reports through analysis of enrollment data from the Medicaid Statistical Information System (MSIS).²

Process improvement collaboratives can improve efficiency and save money, but commitment, buy-in and resources are needed to succeed. Key factors supporting process improvement collaborative success include team members' commitment and buy-in from state officials who have the authority to implement changed processes—as well as to allocate other resources, such as staff time—to test changes. Several states that participated in the CKF process improvement collaboratives have implemented this method as a new way of doing business, and have found that the resources they invest pay off in improved efficiency and, in some cases, documented savings.

Detailed findings about the CKF process improvement collaboratives include:

The PDSA model taught in the CKF process improvement collaboratives is a valuable and effective tool for improving processes.

The process improvement collaborative model instructs teams on using the PDSA model of testing changes: teams plan a process change, implement the change on a small scale, analyze or study results and act on what is learned, either by starting another PDSA cycle or adopting successful improvements into widespread practice (Institute for Healthcare Improvement, 2003). This model was new to nearly all CKF collaborative participants, and they did not find it easy to learn. Developing tests that would isolate just one data element proved difficult. If a team simultaneously reduced the application to one page, revised the application following the literacy guidelines and made it available on the Internet, how would the team assess the effect of each of the three changes on the application rate (see insert on page 7)? Over time, teams grappled with such issues and learned to hone ideas down to one testable element, enabling them to better interpret PDSA test findings.

Teams learned the importance of testing rapid small-scale improvements in ways that helped identify the success of changing one variable. For example, in Oklahoma, the team tested sending a second renewal reminder letter to 20 individuals, and compared the group's response rate to that of a group of 20 individuals who did not receive a second renewal reminder letter. The group receiving the second letter had a higher rate of response, but the team did not know whether the increase was due to receiving the second letter, or to the language in the second letter, which was worded differently from the first letter.

Some participants were initially skeptical of small-scale testing. For example, a team member from one state noted that it was difficult to set aside biases about non-statistically valid sample sizes, and a team member from a different state said that initially, small-scale tests seemed intuitively wrong. However, participants discovered that small-scale testing using the PDSA model taught them about how to test change and measure effectiveness, and in the end, they found it easy to convince others in the state to try small-scale testing (see insert below). Another state's team noted that small-scale testing permitted team members to take risks that they would never have taken on a larger scale.

Small-scale tests provide rapid feedback, which convinced team members that the model worked. For example, in New Hampshire, when clients notify the state of an address change, the state sends them a letter requesting verification, such as a copy of a utility bill at the new address. Without verification, benefits eventually are terminated. Observing that many follow-ups were needed to receive verification, a caseworker theorized that clients were not reading the letter notifying them of the verification requirement. To test this theory, the team sent letters with a highlighted sentence about the verification requirement to eight clients, and sent letters in which the sentence was included, but not highlighted, to four other clients. The team received verifications for six of the eight recipients of letters with highlighted sentences versus one of the four recipients of letters in which the sentence was not highlighted.

Certain factors must be present for states to improve their processes when participating in a process improvement collaborative.

Not all CKF states participating in the collaborative adopted changes as a result of PDSA testing, but successful teams shared some common elements. They include:

- **Decision-maker buy-in.** Decision-maker buy-in at the state level meant that the state would seriously consider changes suggested by the collaborative team, and that the team could use state employees to test and later implement changes. In one state, the collaborative team wanted to test changes that would make it easier to enroll in Medicaid and SCHIP, while state leaders wanted to cut enrollment. Because state

leaders did not support process improvement collaborative goals and would not assign to the team state employees with authority to make changes, this team eventually dropped out of the collaborative. Sometimes teams worked around gaps in the support they received. For example, Idaho did not have any state participation. Instead, the Idaho team focused on changing Medicaid and SCHIP enrollment processes at hospitals, as a result of decision-makers' buy-in at two hospitals. Working closely with their local eligibility office, the two hospitals trimmed eligibility determinations from 45 to 15 days for those who applied at the hospitals.

- **Field worker buy-in.** Since PDSA tests require people to do the testing, buy-in from local level eligibility workers was important. One team, realizing that local worker buy-in was critical, invited local staff to a brainstorming meeting just as the process improvement collaborative began. Local workers felt that they were part of the team and, as a result, generated ideas based on their experiences for the team to test.
- **Balanced teams with the full spectrum of needed skills or connections.** Participants agreed that assembling the “right” team was critical to success. Although each team was unique, those that were successful tended to combine members with the following skills: the ability to champion the issues, generate ideas, control resources (see next bullet), test ideas and analyze data. Some teams did not initially realize that a data analyst was needed, but added such a person after the team was formed.
- **Access to human and financial resources.** Having a team member with authority to direct state resources made team operations easier. For example, the Iowa team included the SCHIP bureau chief and a field office manager, and the Arkansas team included a senior official in the Department of Human Services (which administers the Medicaid and SCHIP eligibility and enrollment function). As supervisors, these team members could direct staff to conduct tests, pull data, or perform other necessary tasks. High-level state officials have many demands on their time, making it difficult for them to commit to multiple team meetings. These officials could nevertheless support the collaborative team by communicating with team members in alternate ways (such as e-mail and voice mail), as the Iowa SCHIP official sometimes did, or by designating someone else who can authorize resources to participate on the team.

- **The willingness of team members to do additional work.** Process improvement collaborative work was not part of anyone’s regular job. It required team members’ commitment and sometimes required working longer hours. If local level staff are unionized, as they were in three of the participating states, then additional or different work can be problematic, or at least require careful planning. One team, which was not successful in implementing any process changes, reported that this was one of its greatest challenges: team members’ work demands left little time to participate in collaborative activities.

Learning sessions and visits from collaborative faculty were two of the most helpful aspects of the process improvement collaborative.

CKF collaborative participants valued the three learning sessions, meetings in which all participating teams came together to learn from experts and share ideas over three days. The three mandatory sessions gave participants access to important information about Medicaid and SCHIP program rules and methods to improve processes. Participants also learned about health literacy—a critical awareness because poor health literacy has been identified by the American Medical Association as “...a stronger prediction of a person’s health than age, income, employment status, education level, and race...” (see insert below) (American Medical Association, 1999).

What is health literacy? Health literacy refers to making all health-related documents, forms, and instructions readable and understandable. According to Maximus’ Center for Health Literacy, “Nearly half of the American public, including most Medicaid recipients, find it hard to understand and use information written above an eighth-grade level. Yet many health-related materials, including benefit explanations and consent forms, are written at tenth- to twelfth-grade reading levels.” Each process improvement collaborative learning session provided focused instruction on health literacy topics, such as writing in plain, familiar language or setting up a user-friendly Web site. Nine out of 10 state teams interviewed by phone specifically cited the CKF process improvement collaborative health literacy training as an important resource. At the one-day evaluation meeting, state officials from Iowa and New Hampshire said that, as a result of the process improvement collaborative, literacy reviews have become a standard practice in their states for all written materials for their Medicaid and SCHIP programs.

The learning sessions gave team members time away from their workplace environments and demands to focus on their process improvement collaborative work. Teams spent most of their time at the three learning sessions in work sessions (a total of nine hours). The second highest amount of time was spent on direct instruction on process improvement collaborative methods (nearly eight hours) (see Table 2). Each session built upon the previous one, with more direct instruction in the first session, and more working sessions by the third meeting. These sessions also facilitated relationships among state teams. Teams shared successes and failures in a nonjudgmental manner, allowing successes to be replicated by other teams without having to be tested, and allowing teams to avoid testing failed ideas. Sessions also motivated teams; the pressure to report progress helped teams meet deadlines. In addition to the learning sessions, teams interacted with the collaborative faculty and each other through 90-minute status conference calls, held in each of the nine months that did not include a learning session. Teams were encouraged to contact faculty if a problem arose, and likewise, the faculty sometimes contacted team members with concerns.

TABLE 2

**CKF Process Improvement Collaborative 2:
Learning Sessions’ Instructional Time**

Task	Total Hours Spent on This Task in the Three Learning Sessions
Team Work Sessions	9 hours
Direct instruction: process improvement methods (e.g., building an effective team, understanding data, using the PDSA process and so on)	7.8 hours
Storyboards (that is, presentation of each state’s progress)	6.8 hours
Client-centered materials (e.g., literacy training)	2.5 hours
Centers for Medicare and Medicaid Services updates	2.3 hours
Lessons learned: state case study examples	1.2 hours

Source: Agendas from learning sessions 1, 2 and 3 of the second CKF collaborative.

In addition to the three learning sessions, Southern Institute staff visited each team in their own state for one day to review and provide an outside perspective on the state's enrollment and/or retention processes. Teams found these visits useful, because faculty often identified problems that might not be evident to team members. For example, one team member said that the team and their colleagues were sometimes too close to the process to identify inefficient processes; the faculty's review questioned the process at each step and helped identify areas for improvement. Teams from four other states concurred. Members of two other teams also said that faculty corroborated team members' views on problems the team had been trying to solve for years; this "outsider" validation reinforced the teams' credibility to officials in their states.

Accessing and using data challenged many participants.

Two types of data are fundamental to the PDSA process. First, teams need baseline data to assess the outcomes of changed processes. Second, teams collect small-scale test data during the "Do" portion of the PDSA cycle; this data must be quickly interpreted and acted upon.

Several teams stressed the importance of having a data analyst—someone dedicated to tracking and analyzing enrollment and retention data—on the process improvement collaborative team. Two teams noted that they added a data analyst after the collaborative began. Other teams understood the need earlier and included a data analyst as a team member from the outset.

Using and understanding baseline and PDSA test data challenged many teams. Not every state had baseline data on application, enrollment, or retention rates and some teams that had baseline data were uncertain of its meaning or usefulness. For example, in New Hampshire, the team began PDSA cycles and found puzzling test results: the changes appeared to have made things worse, compared to state baseline enrollment data. Investigation of state baseline data revealed that the baseline data were based on different definitions of data elements than the team was using. Such findings were not uncommon, and they were critical to helping teams understand the real rates of Medicaid and SCHIP enrollment and retention, in order to know whether a changed process had improved or detracted from those rates.

Collecting data from small-scale tests was easy, but interpreting this data and deciding what to do next was sometimes difficult. Two teams said that “Studying” was the most difficult part of the PDSA cycle: for example, they noted that it took a lot of time to analyze the data, and when results were different than expected, it was difficult to decide what to do next. In the end, most teams agreed that the process improvement collaborative probably improved their analytical thinking, making them better data users.

The process improvement collaborative identified many promising practices that participants believe improved enrollment and renewal processes. Practices that also demonstrated savings or improved efficiency were easier to spread statewide.

When participants identified changes that improved enrollment or renewal processes in small-scale tests, they tried to spread those practices statewide. Many of these changes appear to be applicable in many environments and improved efficiency so much that other states should consider using them. Table 3 shows enrollment and retention processes that were changed statewide. For example, Arkansas implemented phone renewals for Medicaid and SCHIP and aligned the food stamp and Medicaid /SCHIP redetermination dates statewide. The team reported that this decreased the percentage of cases closed for failing to renew, from roughly 25 percent to roughly 6 percent. Iowa automated referrals between SCHIP and Medicaid statewide: referrals grew from 350 to over 800 per month, and staff time to refer someone decreased from 15 to two minutes. New Hampshire began to accept a forwarding address from the U.S. Postal Service as a valid new address and began to verify client addresses during every phone contact with clients. These teams believed these changes would not have occurred, or would have occurred more slowly, without the process improvement collaborative, as other studies on collaboratives also have found (Gold, Krissik and Mittler, 2006).

TABLE 3

Promising Statewide Enrollment and Renewal Practices Developed Through CKF Process Improvement Collaboratives

State	Changed Practice as a Result of Process Improvement Collaborative	Enrollment	Renewal
Arkansas	Phone renewals		x
	Aligned /combined Medicaid redetermination with food stamp redetermination		x
Iowa	Automated referral from SCHIP to Medicaid	x	x
	Only one signature required on child's application	x	
	No signature required on renewal form		x
	Acceptance of faxed signature in Medicaid	x	
	Self-declaration of pregnancy	x	
	Listing county name and worker name on outside of envelopes containing Medicaid or SCHIP identification card, so that returned cards could quickly be directed to the correct worker for follow-up	x	x
New Hampshire	Treating forwarding addresses on returned mail as a valid address		x
	Telephone reminders to mothers of automatically eligible babies to remind them to return renewal forms		x
	Changed expedited birth notification form to include telephone contact information for follow-up	x	x
	Making collateral telephone calls to previous employers to verify termination of employment when such verification is not provided by applicant	x	x
	Verifying client's address at each client contact		x
	Highlighting key lines in letters to SCHIP clients	x	x
Oklahoma	Phone renewals for Medicaid and SCHIP		x
	Implemented 12-month continuous eligibility ^a	x	x
	Revised managed care members' workbook using literacy guidelines	x	
Oregon	Streamlined processes at central processing office	x	
	Aligned asset test for SCHIP with asset test for Family Health Insurance program (a state public insurance program) ^a	x	x
	Implemented 12-month continuous eligibility		x
	Revised client notices to make them user-friendly		x

TABLE 3 continued

State	Changed Practice as a Result of Process Improvement Collaborative	Enrollment	Renewal
Pennsylvania	Implemented applications and renewals by phone	x	x
	Created a centralized system for mailing and collecting signature pages for those who enroll or renew by phone	x	x
	Streamlined renewal processes		x

Sources: Evaluation meeting, June 20, 2006, Philadelphia, PA; Arkansas: e-mail from John Kennedy, July 13, 2006; Iowa: e-mail from Beth Jones on July 5, 2006; New Hampshire: e-mail from Jody Touzin on June 30, 2006; Oklahoma: e-mail from Bonnie Bellah on June 29, 2006, and from Becky Pasternik-Ikard on July 10, 2006; Oregon: e-mail from LoriAnn Sheridan on June 26, 2006; Pennsylvania: e-mail from Ann Bacharach on June 26, 2006.

^aThe process improvement collaborative team believes the collaborative contributed to this change, but was not the sole reason this change was implemented.

Some teams also identified promising practices that they have not yet been able to implement statewide (see insert below). Teams agreed that practices are easier to spread statewide when they demonstrate savings or improved efficiency and require few resources to implement. In New Hampshire, for example, a second renewal notice has not yet been implemented for Medicaid. Though historically shown to increase renewal rates in New Hampshire’s SCHIP program, and shown to increase renewal rates in Medicaid through PDSA testing in the collaborative, limited resources delayed its implementation in Medicaid, although this is planned.

Teams identified promising practices that had not yet spread statewide as of June 2006. These practices include: streamlining workflow in local enrollment offices; allowing subcontractors to update the state database if the subcontractor receives a new address for a client; instituting phone reminders at renewal time; instituting an application checklist at the application processing center; developing a shortened renewal form; creating a new query script for front-line workers to use with clients; and reducing the time it takes to determine eligibility.

The process improvement collaboratives helped participants achieve short-term improvements in processes and long-term changes in the philosophy of state administration.

In the short run, some states achieved sustained statewide process changes. More states identified local process changes that they hoped to spread statewide. For the long run, the process improvement collaborative changed the way some participating states conducted business. For example, Iowa officials have incorporated the PDSA model and health literacy into their daily work: they use the PDSA model for policy formation, personnel evaluations and when

issuing new contracts, and they now review all forms for readability before printing or reprinting them. Oregon officials so valued the process improvement collaborative that they paid for state staff to attend an eight-week process improvement collaborative certification program, to support continued program change using this model. Oregon also reported plans to use the process improvement collaborative model to improve administration of the Food Stamp program. Nearly every team reported that the health literacy training they received transformed the way they look at Medicaid and SCHIP documents.

The process improvement collaborative also fostered relationships within states. Prior to the collaborative, the CKF grantee was sometimes viewed by state and county officials as an adversary, and vice versa. By requiring that advocates and state and local-level Medicaid and SCHIP staff work together, the process improvement collaborative improved communication among these groups. This, in turn, helped them work together more effectively. For example, in Oregon, the CKF grantee had often been at odds with the state over Medicaid and SCHIP processes. However, both groups saw the value in improving processes, and worked together to apply the process improvement collaborative techniques to their central processing of applications. Working together, they streamlined the process from 72 to 16 steps, decreasing the average application processing time from 22 to three days and saving \$28,500 per month in overtime costs. These findings are similar to other studies that have documented the value collaborative participants found in sharing ideas and working together to solve common problems (Gold, Krissik and Mittler, 2006).

The process improvement collaborative supports evidence-based changes. The method can work in any state, but results will depend upon what the state environment can support.

Homer et al. (2005) note that environmental factors could weaken the effectiveness of a process improvement collaborative team. We found that state environments affect what teams can achieve and that changes must be politically palatable to succeed. The CKF grantee in one state, for example, wanted to test the effects of passive renewal, but the state representative on the team knew this was unlikely to be endorsed by the state; thus, it was deemed not worth testing, even on a small scale. Instead, the team focused on phone renewals, which were tested successfully at a local site and later implemented statewide. In another state, the team found it easier to test and implement changes to SCHIP than to Medicaid, because SCHIP enjoyed more popularity among legislators than Medicaid.

Even in environments unreceptive to change, teams found ways to succeed, primarily by focusing on changing those practices that they could control. In Idaho, no state-level Medicaid or SCHIP staff participated on the team, although the state permitted local eligibility staff to participate. Instead of trying to simplify or coordinate state Medicaid or SCHIP processes, the team focused on simplifying and improving Medicaid and SCHIP enrollment processes in specific hospitals. This proved effective, although most process changes were limited to the two hospitals that participated in the process improvement collaborative. However, the process improvement collaborative team worked closely with the local SCHIP office to expedite eligibility determinations for those applying at the two hospitals. The team plans to spread this practice to a third hospital in the state, although as of this writing this change has not occurred (Mary Lou Kinney, personal communication, April 20, 2007).

Participants believe that the improvements to state program administration achieved through the process improvement collaborative would not have occurred without it.

Before the process improvement collaborative, the main vehicle CKF grantees had to promote simplified enrollment and improved coordination was their coalitions. The coalitions provided a platform for grantees to establish a working relationship with state officials, resulting in Medicaid and SCHIP policy and procedural changes in the long term. However, participants reported that the process improvement collaborative was more effective than the coalitions at achieving simplification and coordination changes, for several reasons. First, the collaborative was more narrowly focused on finding ways to make enrollment and retention processes easier in states. At the time the collaborative began, grantees and coalitions were expected to focus on outreach, simplification and coordination strategies, but they mostly focused on outreach, because it was better understood and offered immediate results in terms of enrollment and retention. The collaborative gave these grantees an advantage, by helping them understand simplification and coordination at a more detailed level and showing them how to use those strategies to achieve enrollment and retention results. Second, the collaborative provided resources and tools for making changes, as well as new opportunities for collaboration, which CKF coalitions did not offer. The intensive, structured technical assistance to collaborative teams offered a new and effective way for grantees and states to partner. These tools also focused on achieving rapid process change, whereas the coalitions sustained their focus on longer-term changes.

Third, the collaborative required more intensive involvement from Medicaid and SCHIP officials resulting in more buy-in and greater participation.

The need for resources to conduct a process improvement collaborative and implement recommended process changes could be a limiting factor for states.

State governments may find it difficult to fund improvement programs such as a process improvement collaborative. Although the process improvement collaborative might achieve future efficiencies and savings, the initial expenditures may be difficult to justify. States would need to know the costs and benefits to decide whether to go ahead. In the CKF collaborative, Oregon made a process improvement change that saved \$28,500 per month—\$342,000 per year—in overtime costs. Based on state wages in Oregon, the evaluation team estimates that the costs for a team to do the work (including two eligibility office workers to run tests and collect data, each spending 20 hours per month, one data analyst to analyze data, spending eight hours per month, and one executive level administrator to manage the team, spending two hours per month) would run less than \$10,000 per year (based on pricing found at State of Oregon, 2007). One-time costs for training in process improvement methods, which is available from online universities, are less than \$2,300 for tuition, plus the cost of the staff time to participate in the online course. The cost to administer a collaborative similar to the CKF one would be much higher, including costs for faculty, travel and so on. However, the investment can pay off in improved efficiency and, as in the Oregon instance, documented cost savings.

The need for resources to implement changes statewide also may be a limiting factor. In Iowa, the state had the resources and political support to automate referrals from SCHIP to Medicaid, which reduced referral time from 15 to two minutes and increased referrals from 350 to over 800 per month. In contrast, testing a second renewal notice in New Hampshire's Medicaid program resulted in higher renewal rates, but resources are not available yet to implement this change. In Oklahoma, the process improvement collaborative team tested making change of address cards available in more locations to increase receipt of changed addresses. Although this was successful at the test site, the impact was not large enough for the state to invest resources in making the change statewide.

CONCLUSIONS

The CKF process improvement collaboratives led to improved and more efficient Medicaid and SCHIP enrollment and retention processes in many of the participating states. Given these results, is a process improvement collaborative a worthwhile investment for states? The participants we interviewed from the two CKF process improvement collaboratives—even those from unsuccessful teams—believe that it is, if the key conditions teams need (state buy-in, key team members, resources, team members willing to learn new concepts, etc.) are met. For a process improvement collaborative to be worthwhile, state expectations must be realistic: just as states are not carbon copies of one another, results in each state depend upon the state environment. Clearly, the goal of the process improvement collaborative—to improve efficiency of processes—is relevant to any area of state program administration.

The CKF collaboratives involved teams from different states, but this is not a necessary condition for a process improvement collaborative; in fact, some states have already begun independently pursuing this improvement model. For example, with grant funding from the California Healthcare Foundation, the Southern Institute is conducting a process improvement collaborative involving 13 California counties to improve Medicaid eligibility processes (Southern Institute on Children and Families, 2007). Louisiana Medicaid and SCHIP leaders, who participated in the second CKF collaborative, subsequently contracted with the Southern Institute to conduct a process improvement collaborative with 22 teams aimed at improving enrollment and retention processes in the state's Department of Health and Hospitals, which administers Medicaid and SCHIP.

State government agencies have a fiduciary duty to invest their resources prudently. Like any investment, devoting resources to a process improvement collaborative is a risk: Would it increase efficiency? Would it lead to savings? Our findings, based on experiences attempting to change Medicaid and SCHIP enrollment and retention processes in 21 states, are promising. They indicate that, if properly implemented, states have little to lose financially and much to gain in terms of increased efficiency and savings, from using this model. The process improvement collaborative, which was first a clinical model and has now been adapted to an administrative setting, makes sense.

Endnotes

1. RWJF implemented CKF gradually; it funded the first CKF grantees in 2002 and others in 2003. Most grantees completed their grants by 2006; a small number will finish in 2007. Five states received smaller “liaison” grants to conduct statewide communication campaigns, convene annual statewide meetings of stakeholders and attend CKF regional and national meetings.
2. The CKF process improvement collaboratives occurred in 2004 and 2005. MSIS data for Arkansas is currently available only through mid-2004, so these reports cannot yet be verified.
3. In fact, many businesses use a similar model, known as “Six Sigma,” that was developed by the Motorola Corporation, and have demonstrated significant efficiency improvements and financial savings.

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