CALIFORNIA
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Slowing Medi-Cal Churn:
Counties Collaborate to Improve Efficiency

Prepared for
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by
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Founded in 1990, the **Southern Institute on Children and Families** is an independent nonprofit organization dedicated to improving the well-being of children and families, especially those who are economically disadvantaged.

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I. Background and Introduction

Almost one million California children were uninsured for some or all of the year 2002, despite being eligible for health care coverage under Medi-Cal or Healthy Families (the State Children's Health Insurance Program, or SCHIP).[1] Among them were a large number of children who had been enrolled in these programs but were dropped from coverage either temporarily or permanently, in many cases because of renewal requirements specific to California.[2]

In fact, about one quarter of disenrolled children were re-enrolled within two months. This phenomenon, known as "churning," entails serious health and financial consequences for the affected children, their families, taxpayers, and the health care system. Children with intermittent public coverage are twice as likely as those with continuous public coverage to lack a usual source of care.[3] Further, uninsured children are less likely than those with public or private coverage to receive a well-child exam or proper medical care for common childhood illnesses like sore throats, earaches, and asthma.[4] Delaying care for preventable illnesses can result in the need to access much more expensive care in other settings such as emergency rooms or hospitals.

Churning is extremely expensive to the state, costing an estimated $120 million over three years.[5] It places an unnecessary administrative burden on an already overstressed system in which the caseloads of personnel who determine Medi-Cal eligibility in each county become too large to be handled efficiently. Medi-Cal is a difficult program to administer because of its numerous eligibility categories, each with its own rules governing income, assets, and household composition.

Medi-Cal eligibility workers must also know and act on state and county procedural requirements. County offices are the front line for the California Department of Health Care Services (DHCS), and the work of the local staff directly impacts the lives of customers seeking Medi-Cal coverage.

In an effort to improve the processes of eligibility determination and redetermination, and to maximize the participation of eligible children in Medi-Cal and Healthy Families, the California HealthCare Foundation (CHCF) awarded a grant in 2006 to the Southern Institute on Children and Families to conduct a multi-county Medi-Cal Eligibility Process Improvement Collaborative (MEPIC). MEPIC was an intense 14-month period of learning and applying new knowledge and skills to real work situations in 13 counties to improve the Medi-Cal eligibility process. The participating counties were: Fresno, Humboldt, Lake, Lassen, Los Angeles, Napa, Nevada, Sacramento, San Diego, Santa Clara, Solano, Tulare, and Yuba. This report, which describes their experiences and findings, offers valuable information for other eligibility offices in efforts to improve their processes.

II. Project Design

Orientation

In June 2006, CHCF and the Southern Institute invited representatives of Medi-Cal offices in all 58 California counties to attend a MEPIC orientation. The purpose of the meeting was to determine whether there was enough interest among the eligibility offices in participating in a collaborative. Seventy-nine staff members from 40 counties took part, along with representatives from DHCS and several managed care plans.

Following an explanation of MEPIC's goals and methods, attendees completed an assessment tool to weigh their interest and preparedness for participation in a collaborative. Applications were solicited based on this feedback. Applicants submitted a letter signed by the county director attesting to their commitment to participation, which would include pre-work activities, a conference call, putting together a team, submitting baseline data, and creating a preliminary goal statement. As participants in the collaborative, counties also were committing to attending three learning sessions, participating in monthly conference calls, testing improvement strategies, and analyzing and sharing results in an effort to achieve the team goal.

Fourteen counties responded and were accepted (one subsequently withdrew).

Team Preparation

Two "pre-work" conference calls were conducted by Southern Institute faculty with collaborative members on January 16 and January 23, 2007. During the first call, faculty reviewed the pre-work packet with the teams and responded to questions. The call included a review of team membership, test sites, and test populations. The teams were asked to complete a flow chart of the test site's process for Medi-Cal applications and renewals. They were also asked to create a project storyboard and an organizational profile of the local eligibility office and staff.

Most importantly, teams were instructed to begin assembling 18 months of baseline data on the number of applications received, the number denied, the reasons for denial, the reasons for closure, number of cases closed at renewal, processing times, and caseloads. These core measures, plotted in run charts (or control charts), are essential for determining the effectiveness of changes by documenting stability and shifts in the mean over time.

Four different computer systems are in use in California's 58 counties. Three of them—CalWIN, ISAWS, and LEADER—were represented in MEPIC. The ability of counties to access and extract data varies depending on the system. Unfortunately, these three systems do not use the same "reason" codes to explain denials and closures.

Since the state captures only some codes and not others, many reasons for termination or denial are simply recorded as "other."

A second conference call was held to discuss the problems of data collection, given the disparities in computer systems and reporting parameters. The MEPIC teams determined that they would have to capture the needed baseline data manually.

Learning Sessions

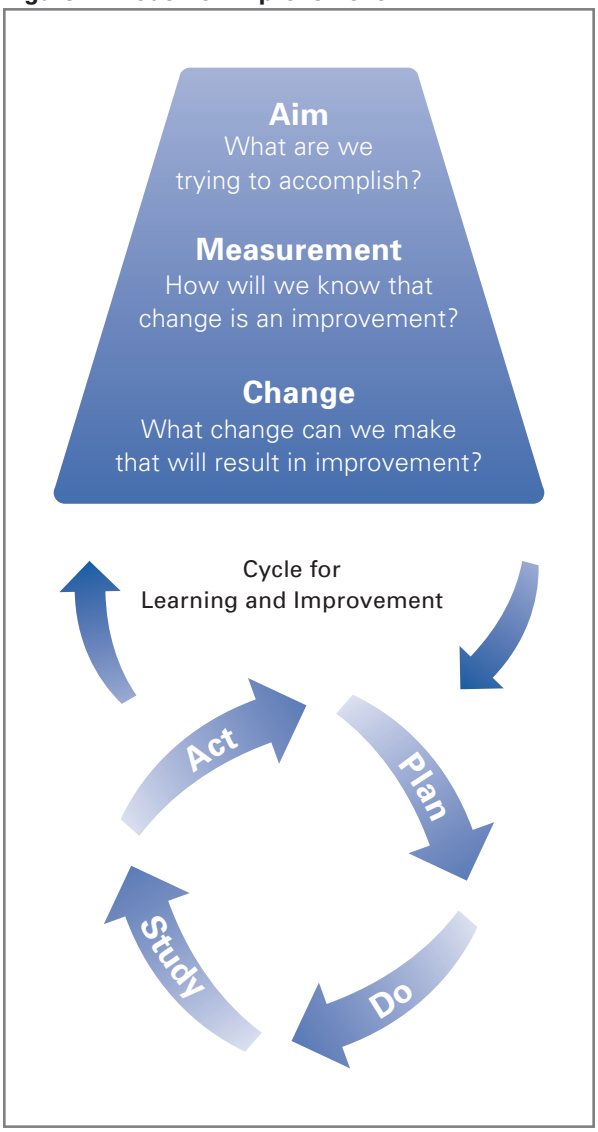
The collaborative consists of three 2.5-day learning sessions and two action periods. During the learning sessions, the teams come together with the faculty and begin to share the results of their testing experiences. Action periods are the times between the learning sessions when the teams go back to their respective offices and put into practice what they have learned. They also participate in group and individual conference calls.

Learning Session 1 was held in Los Angeles March 27–29, 2007. Fifty-seven members from 13 teams were present, along with Southern Institute faculty, the CHCF program officer, two state representatives, and one representative of One-E-App.

Learning Session 1 was designed to bring together all team members—some of whom worked in separate locations—to learn improvement methods and to receive feedback from faculty on their initial plans for testing. As part of a team's preparation for the session, the Southern Institute provided guidance to teams on the key roles that must be played during the life of the collaborative. Eligibility offices participating in MEPIC were required to have a team sponsor whose primary role was to access resources for teams and assist them in overcoming organizational barriers. The core team members had to play a variety of roles: team leader, front line expert, policy/procedure expert, and data expert. In addition, ideally, each team would embody personal characteristics such as enthusiasm, creativity, and analytical and organizational ability, which have been observed to support team-building. Successful collaboratives are dependent upon motivated team members and organizational leaders who are committed to making improvements.

At the session, team members were instructed on how to use the core methodology adapted by the Southern Institute to foster continuous quality improvement. Called the Model for Improvement, the methodology uses the Plan, Do, Study, Act (PDSA) protocol for small-scale testing (see Figure 1). PDSA was originally conceived by Walter Shewhart in the 1930s and later adopted by W. Edwards Deming. PDSA is an ongoing cycle of

Figure 1. Model for Improvement



the following steps intended to achieve continuing improvement.

- **Plan.** Identify strategies that may help achieve a goal and design a test based on the strategy. Look for areas that will offer the greatest return for the change effort.
- **Do.** Test the proposed change on a small scale for a short period.
- **Study.** Analyze what was learned from the test by monitoring significant measures of improvement.
- **Act.** Based on what was learned, decide whether to adopt the change on a broad scale, modify the test and run it again, or abandon the change strategy.

Most teams responded with great enthusiasm. For example:

- Two teams called their offices before the session had ended to have staff begin work on the first PDSA, without waiting for the traveling team to return.
- Many counties arrived at the learning session with a creative team slogan or team name. By the end of the session every team had adopted a name to foster a sense of unity and spirit.
- Two of three teams that presented storyboards on the last day of the session reported they had already made changes to their improvement plans based on what they had learned in the previous days.
- One team began to create a separate database in order to capture information that would be needed, without dependence on the IT department.

Learning Session 2 was held July 9–11, 2007, in San Jose. Again 57 participants from the 13 counties in the collaborative attended. This session was designed to acquaint teams with strategies that have worked in similar organizations.

- Ruth Kennedy, LaCHIP director/Medicaid deputy director, Louisiana Department of Health and Hospitals, described how her state had transformed its Medicaid eligibility process and improved retention through simplification and organizational change strategies.
- Beverley H. Johnson, president and CEO of The Institute for Family-Centered Care, emphasized partnering with families in the development of renewal and enrollment strategies that will produce a higher compliance level.
- Vicki Grant, the faculty's process improvement expert, focused on strategies to identify waste and streamline workflow. The teams were asked to think through the steps required to respond to customer inquiries, prepare for an appointment, respond to no-shows, or handle complex communications.

Learning Session 3, held January 7–9, 2008, in Sacramento, brought together 59 team members from the 13 counties, including the senior leader or team champion from Napa, Lassen, and Solano counties. The chief of the Medi-Cal Eligibility Division was present, as well as other representatives of the DHCS and CHCF.

This final session was devoted to celebration of team achievements, sharing and consolidation of what had been learned, and planning for future work, including spreading improvements. Teams had presented storyboards of their progress at each learning session; the final storyboard depicted the potential impact of MEPIC activities—often dramatic—on Medi-Cal enrollment in their county offices.

Action Periods

During the designated action periods, which were scheduled between the learning sessions, the teams did hands-on planning, testing, analysis, and implementation of selected improvement strategies. Teams also participated in group and individual conference calls and hosted or attended site visits. To facilitate the work, the Southern Institute provided access to a secure Web site through which teams communicated with one another, reviewed one another's PDSAs, checked the results of specific tests when planning similar activities, and adapted forms developed by other teams to their own environments.

Technical assistance was offered, including monthly group conference calls, monthly conference calls with individual teams, site visits by MEPIC faculty, and individual team consultations upon request.

The most frequently requested individual team consultation was with the faculty literacy expert, Penny Lane, a consultant from the MAXIMUS Center for Health Literacy. Working with the teams over the course of the collaborative, Lane raised awareness of the barriers that print materials can present, especially to clients with limited literacy skills. She provided coaching on basic writing and design strategies, and at each learning session gave a presentation including before and after examples of effective and ineffective materials.

III. Team Activities and Results

Selecting and Testing Strategies

Each of the 13 county teams was given an Improvement Strategies Guide, which outlines general concepts and approaches that can positively impact Medicaid and SCHIP enrollment rates, eligibility worker productivity, and customer service.[6] The guide highlights six key concepts, which served as the basis for many of the collaborative PDSAs, as seen in Table 1. The MEPIC teams planned and executed 132 tests within these conceptual categories.

Table 1. Strategies Tested by Improvement Concept

IMPROVEMENT CONCEPT	NUMBER OF STRATEGIES TESTED
Improve Customer Service	58
Improve Workflow	40
Customer/Worker Interface	15
Improve Policies and Procedures	12
Change Work Environment	5
Eliminate Waste	2

County teams most frequently developed and tested strategies designed to improve customer service or improve workflow. Examples of strategies tested and adopted under these two concepts—and some of their immediate results—are highlighted in Table 2 on the following page.

Strategies Adopted

Of the 132 PDSA test cycles conducted and documented by the MEPIC teams, 46 produced changes that were implemented on an ongoing basis. Most of the adopted strategies were designed to improve workflow (19) or improve customer service (16). Less commonly adopted were strategies to improve the customer/worker interface (7), improve policies and procedures (2), or improve the work environment (2). Neither of the two tested strategies to eliminate waste was adopted.

As teams reviewed their processes in search of areas to improve, effective changes identified from others' experiences were also instituted without additional local testing or documentation. For example, after hearing Yuba County and other teams discuss the results of a PDSA test of supervisory reviews prior to closure or denial, Lassen County instituted the practice as well. The outcome was a reduction in erroneous denials—a result subsequently documented by Lassen County as a benefit of MEPIC participation.

Table 2. Examples of Strategies Tested in Customer Service and Workflow

IMPROVEMENT CONCEPT	STRATEGY TESTED
Improve Customer Service	Improve communications (written and oral) • Lake County revised the renewal cover letter and reorganized the renewal packet. This resulted in a 19.5 percent increase in the retention rate. • Santa Clara County revised the renewal cover letter with a verification checklist. The completion rate rose to 85 percent compared to 57 percent for the control group. • Lassen County reorganized supervision of the reception staff from the clerical supervisor to the intake unit supervisor. This enabled the intake supervisor to develop tests involving reception personnel without having to seek permission from another supervisor. The result was increased accessibly of eligibility workers to clients and elimination of bottlenecks in taking applications and receiving verifications. Simplify and improve the process for customers to provide information • Sacramento revised the mail-in cover letter used in the intake packet to request verification by combining the best qualities of three pieces of correspondence (MC355, SC335, and CSF77). This change improved clarity of instructions for clients, decreased the number of denials for failure to provide information, and increased the number of packets received that were complete. The cover letter has been provided to all Medi-Cal intake bureaus for use. Reduce wait time for customer assistance • San Diego removed sign-in sheets at the reception window. The sheets had been used to track the number of people coming into the office. This could result in a time savings of 66 minutes per week if an average of 80 customers come to the window per day and take ten seconds each to sign in.
Improve Workflow	Pull work rather than push work • Napa County instituted the system of "pulling" work rather than "pushing" it. (Instead of having cases assigned or "pushed" onto workers, each worker, as he or she becomes available, "pulls" cases that need to be attended to. This change eliminated a backlog of cases and helped with staff shortages. • San Diego County began providing workers with the actual case file at the time of the intake appointment, which made workers better prepared when they began the intake interview Match staff skills and knowledge to needs • Napa County began to assign work by task, rather than by case, for timelier processing. Reduce unneeded complexity and standardize office operations • Tulare County began processing applications on the day of application when possible. This resulted in a reduction in the number of applications on the pending report and eliminated telephone inquiries from clients about the status of their applications. • Nevada County reassigned workers to specialized caseloads, which made it easier to focus on and manage work. Minimize handoffs and bottlenecks • Sacramento County trained clerical staff to review preliminary data that is downloaded to identify applications that are from clients whose coverage has been discontinued in the last 30 days, in order to decrease the number of applications that should actually be restorations.

Twelve of the 13 teams adopted at least one change validated by the MEPIC methodology; one team adopted 11. Solano County did not adopt any strategies, but the team used the PDSA process to collect and analyze data that helped in designing and planning for a future call center.

Some of the most common strategies implemented by members of the collaborative included:

Verifying contact information whenever there is interaction with a client. Counties identified returned mail due to incorrect or insufficient address as a major area for improvement. Updating clients' contact information at every encounter is an easy strategy to implement and requires no additional staff. Tulare, Nevada, Lake, and San Diego instituted this change.

Rearranging the renewal and application packets to make it easier for clients to distinguish between what needs to be returned and what is purely informational. Counties identified the renewal packet configuration as a possible deterrent to completion of the renewal process. Clients who are overwhelmed and confused often simply do not return anything.

- Humboldt ran a test in which materials that must be returned are clearly identified. The initial result was a 90-percent return rate for the test group with the reorganized packet, compared to a 40-percent return rate for the control group.
- Lake County realized an average 42-percent increase in returned renewal packets over the three-month test period by revising the renewal cover letter and reorganizing the packet into two sections.

Redesigning written materials used in contacting clients—application checklists, cover letters, and reminder postcards. In their efforts to identify reasons clients do not complete the renewal or application process, counties examined the written communications used to convey the eligibility requirements.

- Sacramento revised the mail-in cover letter in the intake packet to request verification by combining good qualities identified from three pieces of existing correspondence.
- Lake County developed a reminder flyer and Yuba County created a reminder postcard to be sent to clients when renewal is due.
- Yuba County recorded an 80-percent response rate when clients were sent a postcard to remind them that a renewal application was due, as compared to a 35-percent response rate for those not sent the reminder.
- Santa Clara saw 69 percent of a pilot group return documentation required for annual eligibility re-determination—77 percent with complete information—when a checklist of verifications to be included was sent out with a revised cover letter. This contrasts with a 39-percent response rate among a control group, only 45 percent with complete information.

Conducting customer satisfaction surveys. Although final results of PDSA tests were not documented by the end of the collaborative, two counties—Nevada and Napa—created a customer satisfaction survey that generated positive results in performance. Fresno created a review sheet to identify error types made on applications submitted by certified application assistors (CAAs) to determine their training needs. The county also created a customer satisfaction survey for the CAAs themselves, to measure the effectiveness of the support they were being given. A verification checklist was designed to assist the CAAs in completing applications and making accurate requests for information.

Redesigning workflow by adopting a "pull" system or team-managed caseload system, as opposed to individual worker caseload management. Counties looking for ways to

eliminate backlogs and overcome disruptions to workflow when no one is available for case assignment were encouraged to consider the strategy of assigning cases to the office as a whole and not to a specific worker.

When Napa County embraced this process, the backlog of pending and overdue applications was reduced. However, the county agreed to let workers revert to the old way of working on their "own" cases, which resulted in a resurgence of pending and overdue applications. The county has since adopted the pull system strategy with the understanding that if workers want to revert to the old way of doing business they must produce data showing that it is more efficient.

Based on the success of Napa County, Nevada and Lake counties also adopted the pull system without testing. Several other teams indicated an interest in this strategy but had not gotten to the point of testing or implementation prior to the end of the collaborative.

Requiring a supervisory review prior to case closure or denial. Recognizing the possibility that cases may be closed or denied inappropriately at the eligibility staff level, Yuba County tested the strategy of requiring supervisory review prior to discontinuance or denial. A senior program specialist who undertook the reviews confirmed that some cases were being denied and closed erroneously. This strategy was adopted by Lassen County also.

Modifying offices and procedures to make them more customer-friendly. Teams began to look at their offices through the eyes of customers. They immediately focused on signage, availability of help, wait times for service, and time spent standing in line.

Several teams tested the strategy of having someone available in the lobby to assist those who simply have a question or need minor advice on completing forms. Other ideas that were successfully tested included: Providing a drop box in which to leave materials; providing a telephone in the lobby so customers can call their caseworker to let them know they have arrived; and removing sign-in sheets to protect the privacy of those who come into the office. San Diego County instituted an answering service for those who call and cannot reach a worker. The San Diego team also appointed a lobby committee to improve first impressions when customers enter the eligibility office. Recommendations that were adopted included:

- Paper notices, admonitory notices, and clutter in general were removed from the lobby to enhance its appearance;
- Window shades were installed in interview rooms to create a more comfortable atmosphere and eliminate glare;
- Staff were requested to page and address all customers with a proper title ("Mr," "Mrs," "Señora," etc.) rather than a first and last name, to convey respect and maintain privacy;
- Messy and mismatched trash/recycle boxes were replaced with clean, clearly marked receptacles to convey a professional business atmosphere.

Measuring Results

The goal of MEPIC was two-fold: (1) increase enrollment and retention in Medi-Cal through the successful adoption of eligibility process improvements, and; (2) foster adoption of the Plan-Do-Study-Act (PDSA) methodology for rapid-cycle process improvement among county social services staff.

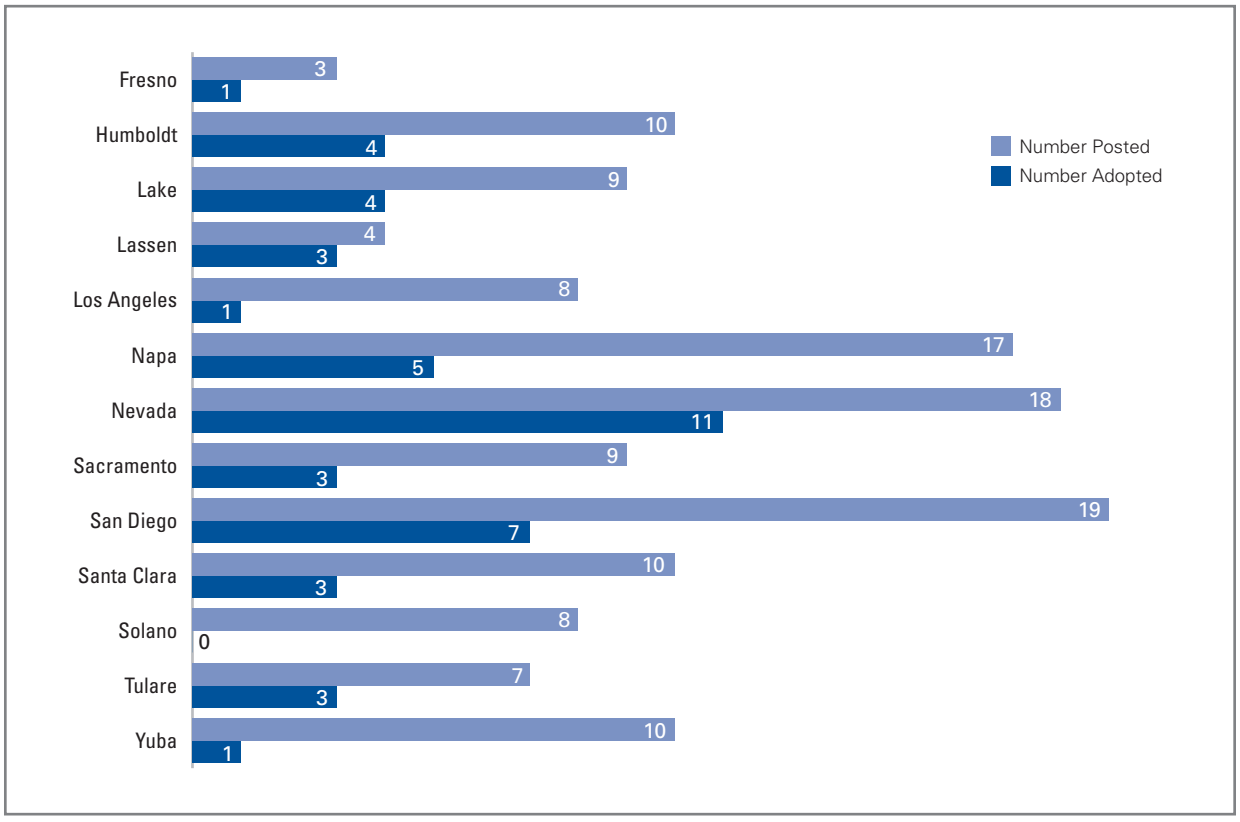
Reports from each MEPIC team showed important achievements toward both goals in some counties, and little or no success on either goal in other counties. Significant variation appears to be related to several factors, including: the authority and commitment of team leaders to lead and support team members; teams' ability to collect and analyze data; and the extent to which MEPIC was viewed as a part of office operations instead of extra work.

Teams that met regularly to plan their tests and discuss findings documented more PDSAs than less-organized teams. Among the most successful teams, improving processes became something in which everyone in the offices had an interest. The least successful teams understood the concept of PDSA, but had difficulty putting it into practice, figuring out what test results meant, and identifying next steps.

Each team faced challenges such as competing priorities, staffing shortages, lack of data, or loss of the team champion. Most teams struggled to meet the deadlines for data and reports. The more focused teams used these barriers as opportunities to find better ways to get things done by eliminating or combining steps and reassigning staff duties.

Figure 2 shows how many PDSAs were posted on the Web site and adopted by each county. It does not take into account tests or strategies adopted that were not posted on the site.

Figure 2. Number of PDSAs Posted Online and Adopted, by County



It should be noted that the number of PDSAs is not a comprehensive measure of a team's effort or success. For example, although the team from Fresno County posted only three PDSAs on the Web site, they achieved their original goal. Other counties tested more strategies, but did not achieve their goal. Additional factors that must be considered include how ambitious and important the goal is, and whether the team is able to sustain and spread its improvement over time.

The specific achievements highlighted below are illustrative but not representative of the results across counties.

Enrollment and Retention

The teams were required to report monthly core measurement data that would be compared to their 18-month baseline data. However the duration of the collaborative was insufficient for changes to be reflected in the core measures. Therefore, teams were asked to project the potential impact using their baseline data from the beginning of the collaborative and the data from their small-scale tests. These projections were highlighted in their Learning Session 3 storyboards.

Results from some of the small-scale tests used to project impact include the following:

- Humboldt County estimated that the improvements could potentially bring $10.7 million in additional state and federal revenues to county medical providers within the first year the goal is met. This amount would compound annually.
- San Diego County estimated that with a 27-percent reduction in discontinuances, about 18,000 fewer applications would be discontinued county-wide in 2008.
- Fresno County reduced the denial rate from 37 percent in the baseline period July 2005 to December 2006 to less than 12 percent in the period April 2007 to November 2007 by concentrating on better training and support of CAAs.

Spreading the Benefits

Several MEPIC teams reported that the collaborative's impact extended beyond the units participating. The PDSA methodology, strategies adopted, and their results were observed and often emulated by other departments within the 13 teams' organizations. Seven teams reported that MEPIC's small-scale PDSA approach had been applied beyond the test site. Five teams reported the methodology was being used throughout the county, and eight teams said the changes have been adopted in programs other than Medi-Cal.

Fresno County provides a useful example of how lessons and techniques from MEPIC could be spread to additional departments. As a result of the MEPIC experience, the county initiated the following activities:

- CORE (Community Outreach Retention and Enrollment) training for designated department managers;
- All projects assigned to SPAT (Special Project Assignment Team) will use the methodology and techniques learned during the MEPIC learning sessions and make use of any applicable information on the Web site; and
- Techniques and methodologies learned will be shared with the 70 new CAAs being brought up on One-E-APP through a grant received by HCAP (Healthy Communities Access Project).

Culture Change

Though difficult to measure, participation in MEPIC appears to have generated cultural change for some organizations. Many of the teams reported that they began to focus more on the customer experience. For example, in response to feedback from a customer satisfaction survey, one county took steps to ensure that workers and supervisors were responsive to messages left on voicemail. Importantly, many counties began focusing on what

they could do to assist the client in becoming eligible rather than sending a request, waiting for the time to expire, and then denying or closing the case.

These were some representative comments on the value of MEPIC participation:

The techniques and methodologies are very useful for all programs and processes. Everyone can benefit from these [PDSAs].

We've improved our operations and customer service. We've learned so much about processes and planning and asking questions and looking at what we do with a new perspective. We would love to have an opportunity to do this again with our continuing cases or with Food Stamp cases.

Great improvement in process. Culture change for staff to embrace change and engage in strategic planning stages. Buy-in ownership in PDSA process alleviated fear of change. If it worked, implement it. If it didn't, tweak it or stop.

Use of Data

Most teams began to understand the importance of data in identifying problems, making decisions, and gaining approval for implementation of changes. Processes were not just "thought" to be effective. Strategies were tested and data were used to verify effectiveness.

In a July 2007 senior leader report, Nevada County highlighted what can happen when a strategy is adopted without preliminary testing:

Specializing continuing caseload: The entire continuing caseload was shifted without testing a smaller sample. The one item we did not pre-test caused the most difficulties. The glitch in planning would still have happened, but it would have been resolved before the rest of the floor was affected and, therefore, would have had a much smaller impact. Always test on a small scale.

IV. Findings and Recommendations

A GREAT DEAL OF INFORMATION CAME OUT OF THE COLLABORATIVE process and its early results that has useful implications for multi-county collaboratives as well as for the policy community. Importantly, the MEPIC proved to be an effective way for California counties to address issues in the eligibility process and make improvements without risk of disruption to the entire office. A number of factors were seen to contribute to the success of the model:

1. County eligibility offices were eager to improve eligibility processes to enroll and retain persons eligible for Medi-Cal. The county teams demonstrated a commitment to change and improve processes so that applicants can be served efficiently and effectively. To that end, the counties willingly shared resources and ideas with one another.
2. The county teams learned, practiced, and incorporated into their work new skills on solving problems in a methodical and disciplined fashion. Using the PDSA model, the teams made significant improvements and were prepared to sustain the improvements and continue applying the methodology.
3. Qualitative feedback gathered from participants for the MEPIC evaluation reflected the profound impact that the experience had on teams, not just in changing work practices to enhance eligibility processing, but also in empowering teams to take charge of the processes through use of a methodology they could apply widely.
4. The mixture of small, medium, and large counties participating in MEPIC provided fertile ground for the exchange of ideas and the building of networks to continue improvements. For the smaller counties, the collaborative offered an opportunity that would normally not have been afforded them because of their size and the perception that any changes they make would have minimal impact on the overall state Medi-Cal population. The diversity of teams reinforced the essential similarity of problems and issues among all counties, and the strategies tested and implemented could be adapted successfully in most of California's 58 counties.

The problems encountered during the collaborative period provided a great deal of valuable information in three broad categories: the state as a collaborative partner, availability of key outcome data, and variation in county infrastructure and commitment.

The State as a Collaborative Partner

Finding

To fully test some ideas, counties need permission from the state to test without penalty. If this permission isn't given, or comes only after a lengthy delay, it can significantly deter efforts to improve county processes.

County eligibility offices are interested in working in partnership with the state to test improvement strategies that will increase efficiency and effectiveness in the delivery of eligibility services, such as redesign of the application and renewal packets and eliminating signatures at renewal (see sidebar).

For example, the table below shows that in three counties, more than a third—and in two cases almost two-thirds—of the cases closed between January and May 2007 were for failure to return the renewal form.

	TOTAL CLOSURES	FAILURE TO RETURN RENEWAL	SHARE OF TOTAL
County A	838	302	36.0%
County B	4,740	3,075	64.9%
County C	17,238	11,167	64.8%

To address this problem, one county developed and tested a revised cover letter/checklist that generated significant positive results documented with data. Approval from the state was needed to introduce the revised form, since the cover letter that was being proposed was to replace a state-required cover letter. Despite county efforts to pursue approval, to date no approval or disapproval of the revised form has been given by the state.

Recommendation

In order to best serve the Medi-Cal population, DHCS personnel and county workers need to act in a mutually supportive manner. Any future MEPIC-type initiative should include a DHCS team of upper management individuals who would be charged with working with the county teams to coordinate interagency communication flow. They would give policy clearances for small-scale tests, and report regularly to DHCS leadership and management on the impact of these tests. Ideally, DHCS would be a sponsoring partner in the creation of an infrastructure for process improvement statewide.

Signature Requirement at Renewal

The requirement of a signature at the time of Medi-Cal enrollment renewal is a state policy that appears to cause customers to lose coverage and thus contributes to churning. The federal government does not require states to obtain a signature at renewal, and does not require the use of a renewal application. Furthermore, the signature on the initial application continues to be legally binding at renewal. California's redundant signature policy bars counties from effectively using convenient telephone or Web-based renewals because transactions must be completed on paper.

DCHS and several counties should work together, using the small-scale PDSA methodology, to test the impact on retention and error rates of eliminating California's signature requirement. If the outcome is positive, the data from the tests would justify the state's reform of this policy.

Availability of Key Outcome Data

Finding

A foundation of the MEPIC process is a solid baseline of outcomes data for assessing the impact of improvements over time. Therefore counties were required to assemble 18 months of baseline data on the number of applications received, the number denied, the reasons for denial, the reasons for closure, processing times, and caseloads.

However, most of the counties and their eligibility workers did not have access to reliable outcomes

data. Some teams found that the measurements could not be extracted readily or accurately from the ISAWS or CalWIN systems. Several counties purchased software as an add-on to extract the desired data from CalWIN, but this was not an option for all users of the system because of financial constraints. Los Angeles County, which uses the LEADER system, had no problems obtaining the desired data since reports had previously been generated when a county team participated in a Southern Institute Collaborative in 2000, and the measurements were still being collected.

To assist the teams with their data collection problems, the Southern Institute held conference calls with a technical representative for the CalWIN and ISAWS systems and with DHCS state representatives to determine if the desired data might be available through the state's MEDS system. However, no solutions were forthcoming, and ultimately the teams agreed to collect data manually and collaborate with each other in the development of a request for computer services (RCS) to have the desired reports created. Such a request requires that all counties participating in the system must be consulted and in agreement before changes are made.

During the collaborative action periods, most teams based their decision-making on data collected during small-scale testing. Typically these measurements were recorded manually and entered into a spreadsheet for analysis.

Recommendation

Without reliable outcomes data, eligibility workers and managers have no way to identify problems in the process. Further, if the counties do not have the data and tools to understand their work processes, then DHCS does not have the vital information it needs to lead and to establish policy. It would be worth the short-term investment for DHCS to assist the counties and other stakeholders in developing eligibility outcome measures that can be extracted and used for continuous improvement. In the meantime, counties can and should continue to collect the small-scale data over time to assure that the improvements are sustained. When the improvement is spread beyond the test site to the larger office, the data should be collected in a systematic fashion.

Variation in County Infrastructure and Commitment

Finding

There was substantial variation among teams in the level of engagement of county leadership, use of the PDSA methodology to test ideas, and ultimate adoption of successful strategies. Some variation in the collaborative process results are to be expected. Limited time and resources can cause testing to be curtailed and prevent team participants from fulfilling their obligations in the project. A few teams lose momentum and commitment to the goals, and even the best teams can run into organizational issues that impede their progress.

Some variation in effort and outcomes is a natural outgrowth of the inclusiveness of the collaborative's model. While raising the standards for participating in the collaborative might reduce variation in outcomes, it could also discourage some groups from participating. Such a result may or may not be desirable, depending on the goals of the sponsor, the participating organizations, and the fixed and marginal costs of including more teams in the collaborative.

Recommendation

The collaborative process makes it clear that to be highly successful over time, teams need an organizational structure that supports its work, facilitates communication throughout the organization, and provides easy access to senior leaders. Obstacles to maximum team effectiveness are best overcome when the organization's leadership and team sponsor have the authority and commitment to quickly address and resolve the issues. These comments were offered by two senior leaders:

As director, I see that I need to spend more time training my staff in problem-solving techniques and encouraging them to focus on solving problems instead of figuring out who or what to blame.

Involving county executive-level actively in core team activities ensures team engagement, accountability, timely next steps/actions, threading of appropriate parties (operations, program training, QA/QC, community collaboratives, etc.), and a fluid vehicle to spread throughout agency operations.

Future collaboratives should consider requirements and mechanisms to ensure adequate commitment by county leadership and teams. The development of a team charter detailing its goals, expected results, work plan, and membership, is a useful tool. Future collaboratives may want to secure a memorandum of understanding with those receiving technical assistance; the MOU would describe expectations about the level of county participation and commitment.

At the outset, collaboratives should identify strategies to address variation in commitment and performance mid-course. They may want to establish benchmarks and put mechanisms in place to identify variation early on. It may also be useful to determine, in advance, where their limited technical resources should be focused—to the lowest performers, the middle performers, or to the highest performers?

Conclusion

The MEPIC initiative is a work in progress. Counties continue to report improvements that are taking place as a result of the tools they learned and strategies they developed through the collaborative process. However, a full assessment will take time, as we monitor the impact in terms of sustainability of the improvements, their spread to other offices within a county and across counties, and the development and testing of new ideas.

Endnotes

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