This report was prepared for the Agency for Healthcare Research and Quality (AHRQ) by Mathematica Policy Research and its

Transforming service delivery to promote quality of care

Program objectives

CMS asked States to develop projects that would test new or improved provider-based models for providing health care services to children and their families. Fourteen States felded projects in this topic area,[7] examining service delivery models in settings such as pediatric and family practices /TT3 1 Tf-0.01 Tc 10 0 0 10 36 645.i45.i45.i45.i45.im70 0 0 10 36 .098.97

- Practices need a variety of supports to remain engaged in learning collaboratives and other QI activities (for example, technical assistance, practice facilitators, stipends, MOC credits). States also can use web-based learning sessions to supplement or replace in-person meetings to make attendance easier, especially for practices in rural or frontier communities.
- With encouragement from the State, practices used a self-administered assessment of medical homeness that tracked changes over time and helped focus QI activities on areas most in need of attention.
- Most practices lack the technical competencies to gather the data needed to implement and track practice-level QI efforts. Although learning collaboratives can help build providers' capacity, not all practices want to improve data collection and measurement skills; some view the burden of data collection and measurement activities as outweighing the benefits.
- Some States hired practice facilitators (sometimes called QI specialists or coaches) to help practices and SBHCs develop QI teams, identify and undertake QI activities, and collect and analyze data to track progress. To be effective, practice facilitators need to: (1) possess strong interpersonal skills that support practice engagement; (2) have technical knowledge in quality measurement, QI strategies, and clinical content areas; and (3) have caseloads that permit them to spend sufficient time with a practice or SBHC.
- SBHCs may have limited experience in engaging youth in discussions about their own health and health care. States can help SBHCs by hiring youth engagement specialists who can assist in hosting workshops for youth and health literacy training for SBHC staff, and practice facilitators who can help gather and review data to inform SBHCs' clinical services.
- Developing sustainable methods for systematically engaging families

Applying health information technologies (IT) for QI

Program objectives

CMS encouraged States to develop and enhance current health IT applications, establish links among databases, provide incentives for the adoption and use of health IT, analyze health IT data, and implement QI activities based on the analyses. Federal policymakers were looking to this demonstration to provide information on the use and impact of health IT to improve child health care quality and reduce costs, and to inform technical assistance to promote broader adoption of health IT. CMS' grant solicitation required States to coordinate with other Federal grant programs underway at the time[8]

State strategies

Fourteen demonstration States implemented health IT projects,[9]

Using Federal grants to build intellectual capital at the State level

The demonstration allowed State staff and their partners to gain substantial experience, knowledge, and partnerships related to QI for children in Medicaid and CHIP—a resource we refer to as "intellectual capital." Although the CMS solicitation did not identify this outcome as a specific objective of the grant program, all 18 demonstration States developed this resource in some fashion.

State strategies

Specifically, the demonstration grants allowed States to build intellectual capital through one or more mechanisms, such as:

- Contracting with State universities or medical schools to develop and implement the demonstration projects, often expanding the scope of work specifications of existing contracts.
- Supporting State staff directly to develop the partnerships, inter-agency agreements, and subcontracts necessary to enhance a State's capacity to report quality measures and implement QI activities.
- Developing new administrative entities in or closely aligned with the Medicaid agency that have specific responsibilities and authority to implement QI activities for children enrolled in Medicaid and CHIP.

In **Idaho** a new entity—the Idaho Health and Wellness Collaborative for Children (IHAWCC)—was developed to capitalize on intellectual capacity created during the demonstration. This new pediatric improvement partnership is a coalition of clinicians and stakeholders—including representatives from the State's Medicaid program—that is invested in using measurement-based efforts to improve the quality of children's health care. IHAWCC will use what was learned during the demonstration to continue offering learning collaboratives to enhance the QI capacity of clinicians and health care quality.

In **South Carolina**, demonstration staff will work with other State staff to transition PCMH responsibilities to a new unit in the State's Medicaid agency (the Pediatric Quality Unit).

Lessons learned

Because of the demonstration, States had an opportunity to enhance their technical and administrative experience with QI initiatives for children. Analysis of information from stakeholder interviews indicates that States benefitted from this opportunity in a variety of ways:

- Having dedicated staff and resources for a 5-year period allowed most demonstration States to think about sustaining long-term strategies for improving children's health beyond the immediate task of implementing demonstration activities. Over half of the programmatic elements that had been implemented by the end of demonstration's 5th year had been or were likely to be sustained.
- In several States, the experience and resources developed to improve quality of care for children were subsequently applied to adult populations.
- Some States contributed substantial in-kind resources to support demonstration activities and, in doing so, worked to raise awareness about child health issues across their administrative agencies and across the State. The intellectual capital derived from the demonstration helped ensure that children and children's health issues would be a part of broader conversations about health care payment reform and quality measurement and reporting.