The CHIPRA Quality Demonstration Grant Program

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded 10 grants, funding 18 States, to improve the quality of health care for children enrolled in Medicaid and the Children's Health Insurance Program

Background

CHIPRA established a series of initiatives to improve the quality of children's health care and, more generally, helped to bring a pediatric focus to a broad range of Federal quality measurement efforts. In addition to the Quality Demonstration

Carolina is reporting measures from claims data (in addition to other sources, such as immunization registries) to leverage their existing sophisticated quality reporting system.

Attributing patients to providers.

Determining which children each practice should be held accountable for is a critical and common challenge for States reporting the Initial Core Set or other measures at the practice level. Generally, claims and encounter data indicate which provider (and not which practice) a patient visited. Claims do not contain information about which providers work together, making it difþcult to develop practice-level patient assignments. Massachusetts is addressing this problem by using Massachusetts

Mismatch between EHR capabilities and measurement generation needs. The States are reporting measures not currently specified for use with EHR data. To pull information from EHRs, a few States are attempting to map the measure specifications to discrete EHR fields for one or more major vendors as a test case. They face a number of challenges.

> "We are finding that the HIT [health

First, EHRs store needed information in a variety of ways, as a result of product design or user preference. One EHR, for example, may have a check box to indicate if a patient is contraindicated for a vaccine, whereas another may store that information in a drop-down box. Second, EHRs may not support, or a provider may not use, the discrete fields needed to calculate measures. Data that reside in free text instead of discrete fields are difficult to use for quality measurement with current technology. Third, EHR vendor and product selection is not static. Some practices have switched EHR vendors during the first 2 years of the demonstration, and even if they have stayed with the same vendor, the product can change. As EHR specifications for measures are released, States will continue to face these challenges if providers use non-certified systems or record data outside of the discrete fields.

Collecting data from State-level data systems. The demonstration States are collaborating across agencies to gain access to needed information and to improve the long-term quality and sustainability of existing data systems. For example, Massachusetts convened a broad group of stakeholders to work on a variety of child health issues including the spread of provider-level reporting efforts.

Another example of cross-agency collaboration is the production of childhood and adolescent immunization measures at the practice level in North Carolina. The immunization measures will rely on data pulled from three different data systems that have not previously "talked" to each other: paid Medicaid claims, the North Carolina Immunization Registry, and the Health Service Information System (a billing system). This required State staff to add new data fields and elements, which entailed corresponding changes to databases and new training for individuals who work with these systems. Similarly, Maine's demonstration staff are collaborating with a large group of agencies and stakeholders to enhance the reporting capacity of the State's immunization registry.

Conclusion

Four demonstration States are experiencing similar challenges in implementing practice-level reporting of the Initial Core Set of quality measures. Each State is developing strategies from scratch to some extent. Although they are pursuing unique or customized strategies, inefficiencies also are created. Practice-level reporting efforts could be accelerated through the provision of technical assistance to help States develop solutions to the kinds of challenges described in this Evaluation Highlight.

Recent reviews and commentaries on health information exchange and quality measurement in the larger health care environment suggest that the range of technological and administrative challenges States have faced while trying to provide practices with timely and accurate Medicaid and CHIP measures for QI are similar to those affecting other efforts to develop practice-level reporting. [4,5]

Nevertheless, the demonstration States have made progress over the last 2 years. Providers in Pennsylvania indicated they are initiating new QI efforts as a result of CHIPRA practice-level reports. To increase well-child visits, for example, clinics are redesigning reminder letters and completing reminder calls earlier in the month when parents are more likely to have available cell phone minutes. In addition, demonstration staff and stakeholders in Maine indicated the CHIPRA demonstration is increasing the pediatric focus of quality measurement in the State. For example, Pathways to Excellence, a public reporting initiative, added immunization measures aligned with the Initial Core Set to their list of measures reported by practices to receive Good-Better-Best quality rankings.

Implications

The early experiences of the four demonstration States highlighted here suggest some insights that other States interested in practice-level quality measurement may want to keep in mind. Specifically, States could:

- Involve providers in the measurement selection and testing process to help ensure the measures are useful for practice-level QI efforts.
- Reserve resources in advance for carefully planning how measures will be calculated at the practice level.
- Provide support to practices actively participating in data collection. Support could include financial incentives, staff support, or training.