Evaluation Highlight No. 4, October 2013

This Evaluation Highlight is the fourth in a series that presents descriptive and analytic findings from the national evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstration Grant Program. Historically, it has been challenging for child health advocates and stakeholders to keep children and adolescents high on States' policy agendas because of State budget constraints and competing priorities. However, the CHIPRA quality demonstration grants have provided a unique opportunity not only to advance child health quality in the short term, but also to link child health quality issues to broader Federal and

Our analysis is based on work completed by the States during the first 2 years of their 5-year demonstration projects.

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KEY MESSAGES

The experiences of these five CHIPRA quality demonstration States may be helpful to other States that are trying to focus attention and resources on child and adolescent health issues.

Key messages from these States include:

- States have aligned their efforts with ñ and used their CHIPRA quality
- Ongoing engagement with a range of public and private stakeholders has both elevated child and adolescent health considerations and informed ongoing activities related to health care payment reform and quality measurement and reporting.

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- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The demonstration began on February 22, 2010 and will conclude on February 21, 2015. The national evaluation of the grant program started on August 8, 2010 and will be completed by September 8, 2015.

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Transformation Center, which will support CCOs through technical assistance and learning collaboratives, will sponsor a learning collaborative aimed at connecting child health providers with early education providers. The State's experience in the CHIPRA quality demonstration informed that planning process.

In addition, Oregon's experience with producing quality measure data using the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)[11] has given the State a better understanding of the utility of those measures. Oregon applied that insight in its discussions with CMS around the identification of the measures that should be produced and evaluated to determine effectiveness for its CCO demonstration waiver.

Some demonstration States also chose to link their efforts to existing health IT initiatives funded through the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009.[12] For example, in addition to expanding its statewide medical home initiative to pediatric practices, Vermont also used CHIPRA quality demonstration funding to broaden its existing web-based clinical registry (known as DocSite) to include pediatric providers. DocSite was also expanded to include some of the Child Core Set of quality measures, as well as other pediatric performance measures selected by a diverse group of stakeholders in the State. Vermont also hired an additional practice facilitator to work exclusively with child-serving practices on a range of issues, including electronic health record (EHR) adoption, achievement of meaningful use, participation in and use of DocSite, and connection to the State's health information exchange. Although this expansion to pediatrics was already on the State's agenda, CHIPRA quality demonstration funding accelerated the timeline for implementation and allowed the State to provide additional technical support to participating practices. In addition, its direct support of child-serving practices helped foster provider buy-in to the State's ongoing reform eύ†ʿ m eύ†ʿ - MŸ \ ک ¾M ӟ Җ going

- Create opportunities for the child and adolescent health community and other knowledgeable stakeholders to collaborate and work more effectively on incorporating the needs of children and adolescents into the development of new quality measures and payment and delivery system reforms.

The strategies adopted by these States, and their specific near-term impacts, are to a certain extent unique, as they reflect the context in each State. However, the common thread running throughout these efforts is represented by the new connections being formed among State officials, policymakers, providers, staff of various reform initiatives and demonstrations, and other key stakeholders.

Implications

The early experiences of the demonstration States highlighted here suggest some promising practices and lessons that other States may want to bear in mind as they look for ways to effectively address child and adolescent health issues:

- Convening and facilitating regular, ongoing dialogue among policymakers and diverse child health stakeholders, including respected child health experts, to engage a broad base of constituencies. Such ongoing dialogue can provide a vehicle for policymakers to obtain input on policies that may affect child health, and it can help to increase buy-in for adapting those policies to meet the health needs of children and adolescents.
- Building on related reform efforts can help to facilitate dialogue and problem-solving among stakeholders who may not typically work together. This is particularly relevant to the child and adolescent population, where the public health and civic sectors also provide essential services and complement the health care system.[4]
- Elevating child and adolescent health issues on State policy agendas requires an ongoing process rather than a single intervention. Demonstration States are already beginning to identify sources of support to sustain stakeholder coalition and quality efforts after the CHIPRA quality demonstration grant ends in 2015.

Endnotes

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5 Young K, Garfield R, Musumeci M, Clemans-Cope L, et al. Medicaid's role for dual eligible beneficiaries. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2012.

6 Rosenbaum S. The Patient Protection and Affordable Care Act and the future of child health policy. Acad Pediatr 2012;12(5):363-364.

7 Simpson LA, Fairbrother G. How health policy influences quality of care in pediatrics. Pediatr Clin N Am 2009;56(4):1009–1021.

8 For more information on Oregon's PCPCH program, see: Stenger RJ, Smith J, McMullan JB, et al. Defining the medical home: the Oregon experience. J Am Board Fam Med 2012;25(6):869-877.

9 Devers KJ, Foster L, Brach C. Nine States' use of collaboratives to improve children's health care quality in Medicaid and CHIP. Acad Pediatr 2013;(forthcoming).

10 CCOs were established in a 2011 State law. For more information on Oregon's CCOs, see: Stecker, EC. The Oregon ACO experiment – bold design, challenging execution. N Engl J Med 2013;368(11):982-985.

11 US Department of Health and Human Services, Centers for Medicare & Medicaid Services. CHIPRA initial core set of children's health care quality measures. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

12 Gold MR, McLaughlin CG, Devers KJ, et al. Obtaining providers' "buy-in" and establishing effective means of information