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 (CHIP). Funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

Background

In early 2011, the Centers for Medicare & Medicaid Services (CMS) released the Child Core Set measures to track the quality of care provided to children in Medicaid and the Children's Health Insurance Program (CHIP). Measures in the Child Core Set cover a range of health domains, including prevention and health promotion, management of acute and chronic conditions, the availability of care, and family experiences of care. The measures are generally calculated as the percentage of qualifying patients that received a recommended service (for example, the percentage of 6-year-old children with a well-child visit in their 6 th year). Since 2011, CMS has encouraged all States to report to CMS annually on these measures for children enrolled in Medicaid and CHIP. [1]

Ten of the 18 States participating in the CHIPRA quality demonstration are

CHIPRA demonstration staf are the main vehicles for imparting lessons.

Both of the larger health systems have earned incentive payments. One earned $120,000 for baseline reporting and $70,000 for improvements on four measures in the frst follow-up year. The other earned $180,000 for baseline reporting and $50,000 for improvements in the frst followup year, also on four measures. In both cases, the health systems had decided to pursue improvement projects only for measures with a baseline value of 89 percent or lower. Table 1 lists some of the QI strategies that practice sites implemented.

South Carolina used the Child Core Set Measures as a foundation for assisting primary care practices

In South Carolina, the CHIPRA project requires participating primary care practices to design, execute, and document plan-do-study-act (PDSA) cycles using the quality-of-care concepts established by the Child Core Set but adjusted to the time period selected for the PDSA cycle. In PDSA cycles, the practices defne a quality improvement aim related to a Child Core Set measure, test an approach to achieving that aim, measure and refect on the results, and then refne the approach in a series of short-term cycles. Practices document their PDSA cycles (at least three or four per quarter) on a project blog, along with minutes from internal QI meetings.

To educate practices about the Child Core Set and PDSA cycles (among other QI topics), the South Carolina CHIPRA demonstration convenes semiannual in-person learning collaborative sessions, and demonstration staf visit individual practice sites. Midway through the demonstration, a QI specialist was hired to advise practices on how to implement efective QI activities.

Each practice selects measures to address through PDSA cycles. As of December 2012, three measures accounted for half of all documented PDSA cycles. These were: developmental screening in the frst 3 years of life, asthma-related emergency department (ED) visits, and preventive dental services. CHIPRA demonstration staf had reviewed 14 of the 24 Child Core Set measures during learning collaborative sessions by December 2012. CHIPRA demonstration staf observed mixed performance across the 18 practices participating in the project. Some practices contribute fully to collaborative sessions and blog postings. Others meet minimum requirements. Some practices successfully use PDSA cycles for QI and transform successes into new ofce protocols. Others use PDSA cycles as a mechanism for documentation but fail to do the followup work to demonstrably improve, according to demonstration staf. Table 2 lists some of the QI strategies practices implemented.

Practices in both States grappled with clinical documentation limitations and worse-than-expected baseline performance

When health systems and practices began their projects, they commonly found they could not accurately assess their current or recent performance because of incomplete or inconsistent documentation in EHRs and paper charts. Before systems or practices could measure improvement, they frst had to improve documentation and convey the importance of improved documentation to all relevant staf. Physicians who paid proper clinical attention to a matter were displeased when documentation did not match their performance. To the Pennsylvania CHIPRA demonstration staf, this realization is precisely the point of their project. One team member said, “Until you get your EHR up to speed with what you’re doing clinically, your EHR is falling short.”

Even when documentation was more complete, most practices found their performance was worse than expected on some measures. A South Carolina physician said, “Last year, a point of emphasis was developmental screening. We were already tipping our toe into that, but [the requirement to do PDSA cycles] helped formalize the process, and gave me an incentive to measure where we were. I knew what I was doing for developmental screening and I had told other people what we should be doing, but I didn’t really go and look. I think we all assume we are doing a really good job but until you capture those metrics you don’t know. It can become a big ‘ah ha’ moment.”

Friendly internal competition and teamwork were useful improvement strategies

Efforts by Pennsylvania and South Carolina to get health systems and practices to improve spurred a healthy rivalry among individual providers. For example, one of the Pennsylvania health systems believes annual measurement of system-level performance will not motivate improvement. The health system is designing a dashboard of physician-level measures, produced monthly or quarterly, expressly to promote friendly competition among physicians. In South Carolina, one practice leader who shared physician-level performance statistics among physician colleagues said, “There is nothing punitive about it, but I let them know in front of everybody that their ratio is low. That usually fixes the problem.”

The health systems and practices we visited said many QI activities require the involvement of physicians, nurses, and administrative staff to succeed. To be involved effectively, all staff must be aware of quality measures and why they matter. While some practices were struggling to increase awareness and teamwork, most mentioned these as explicit goals. A South Carolina physician commented, “Everybody has to understand that change is not one person’s job, it is the practice’s job.”

In Pennsylvania, one practice’s success at making all members of its staff aware of its goal of increasing well-child visits led it to adopt changes suggested by administrative staff. Specifically, when office staff tried to make reminder phone calls to parents to schedule visits, they noticed that many parents had run out of

Clinicians and States identi ed key ingredients to sustaining QI efforts

The keys to sustaining measure-driven QI e orts were:

- Investment in both the human and automated components of data extraction and reporting. To conduct QI activities e ciently, practices must be able to query EHRs to extract and report quality measures. In South Carolina, some participating practices still need to invest in this level of automation because their EHRs do not generate the reports they need. In Pennsylvania, by contrast, these basic functions were mostly automated, but investment in programming and analysis by humans continues. Each time an EHR is modi ed, for example, programmers and analysts must reconsider data coding and measure calculation and modify procedures. When it comes to sustaining QI e orts, not everything can be automated.

- Commitment to EHRs as the quality infrastructure. Regular and better use of EHRs is needed to make measure-driven QI activities the "normal way of doing things." The need for an EHR focus was built into Pennsylvania's pay-for-performance project, but several South Carolina practices also mentioned it. The idea is to make the EHR the infrastructure that ensures "best practice" care by building into the EHR functionality that supports appropriate clinical workow and decision support. Otherwise, as a South Carolina practice explained, QI e orts are too easily disrupted when a practice must respond to events such as illness outbreaks or sta ng changes.

- Broader family engagement. Many of the denominators of the Child Core Set measures include all eligible children . As practices began to accept this level of accountability, they took steps to promote patient awareness, knowledge, and compliance and paid more attention to communicating e ectively with patients and families. Previously, some practices and health systems said they had been satis ed providing high-quality care to children who visited the o ce (as opposed to all eligible children).

- Reimbursement for delivering recommended servicesPractices are most likely to sustain QI interventions related to services for which they are reimbursed. In South Carolina, the three measures most commonly used in PDSA cycles measure the receipt of services for which practices can claim reimbursement through Medicaid. In contrast, the CHIPRA demonstration sta had more di culty getting practices to engage in motivational interviewing (to help persuade patients and families to modify behaviors linked to being overweight), despite o ering training in the technique. Practices do not have a way to bill the South Carolina Medicaid program for providing that service, according to

Implications

The first Highlight in this series alerted States that testing the Child Core Set measures for practice-level reporting is a time- and resource-intensive task. This Highlight identifies several further considerations for States as they encourage health care providers to use the Child Core Set measures to support QI efforts:

- Letting providers select measures