The Role of Measurement in Improving the Care of Children Covered by Medicaid and CHIP

2nd Annual CMS Medicaid/CHIP Quality Conference
Improving Care and Proving It!
June 14-15, 2012

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Outline

- Overview of AcademyHealth
- Why measure quality in child health care?
- Expanding our toolbox for measurement
- Turning measurement into action
- Concluding thoughts

AcademyHealth: Improving Health & Health Care

AcademyHealth is a leading national organization serving the fields of health services and policy research and the professionals who produce and use this important work.

Together with our members, we offer programs and services that support the development and use of rigorous, relevant and timely evidence to:

1. Increase the quality, accessibility and value of health care,
2. Reduce disparities, and
3. Improve health.

A trusted broker of information, AcademyHealth brings stakeholders together to address the current and future needs of an evolving health system, inform health policy, and translate evidence into action.

Why measure quality in child health care?

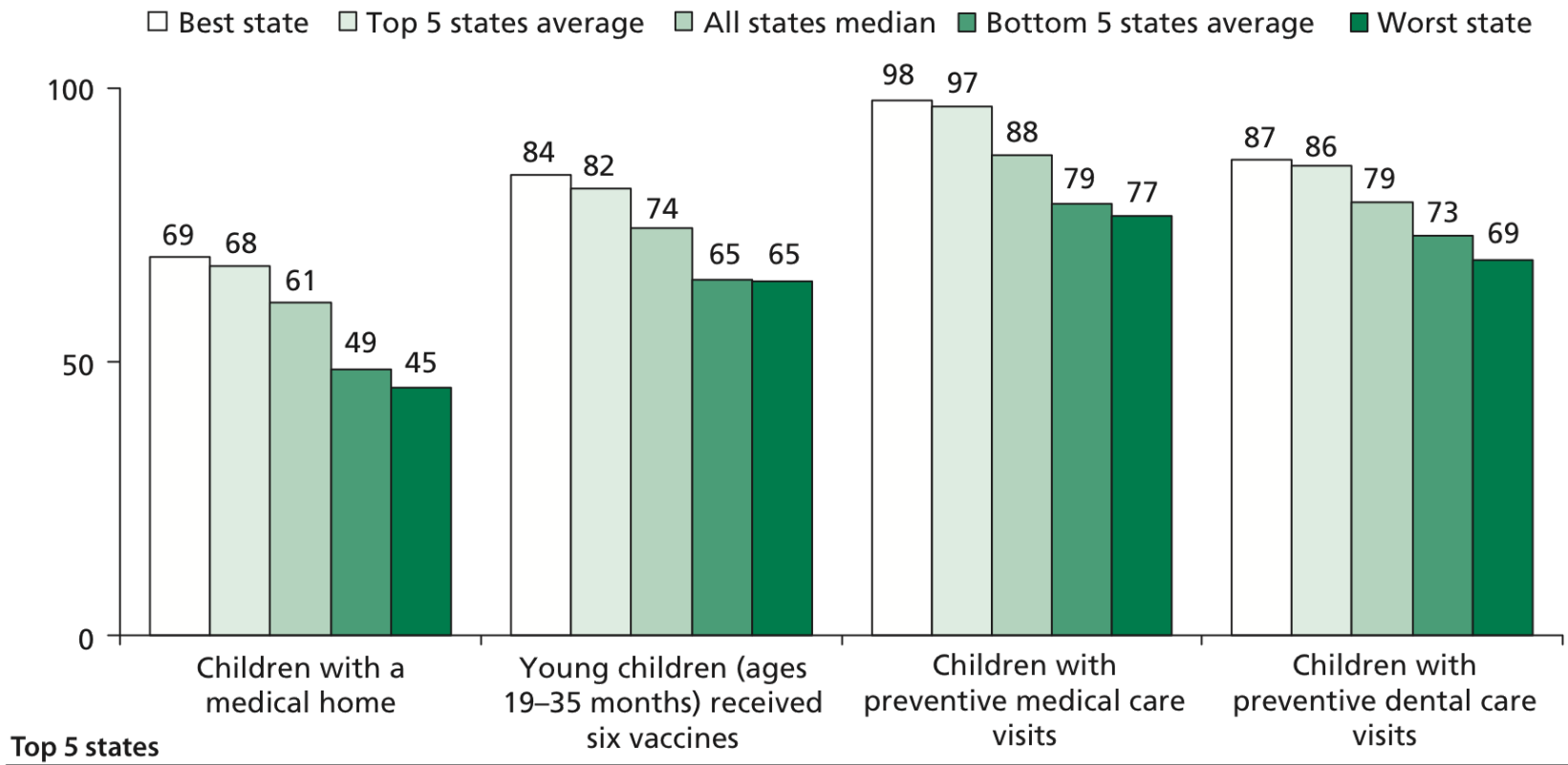
"What gets measured gets done!"

American Children are Underserved

- On average, according to data in the medical records, children in the study received 46.5% (95% CI: 44.5 - 48.4) of the indicated care (ambulatory only).
  - 67.6% (95% CI, 63.9 - 71.3) for acute medical problems
  - 53.4% (95% CI, 50.0 - 56.8) for chronic medical conditions
  - 40.7% (95% CI, 38.1 - 43.4) for preventive care.

Source: Mangione-Smith, et al. “The Quality of Ambulatory Care Delivered to Children in the United States.” N Engl J Med 2007; 357:1515-1523

State Variation: Medical Home and Preventive Care

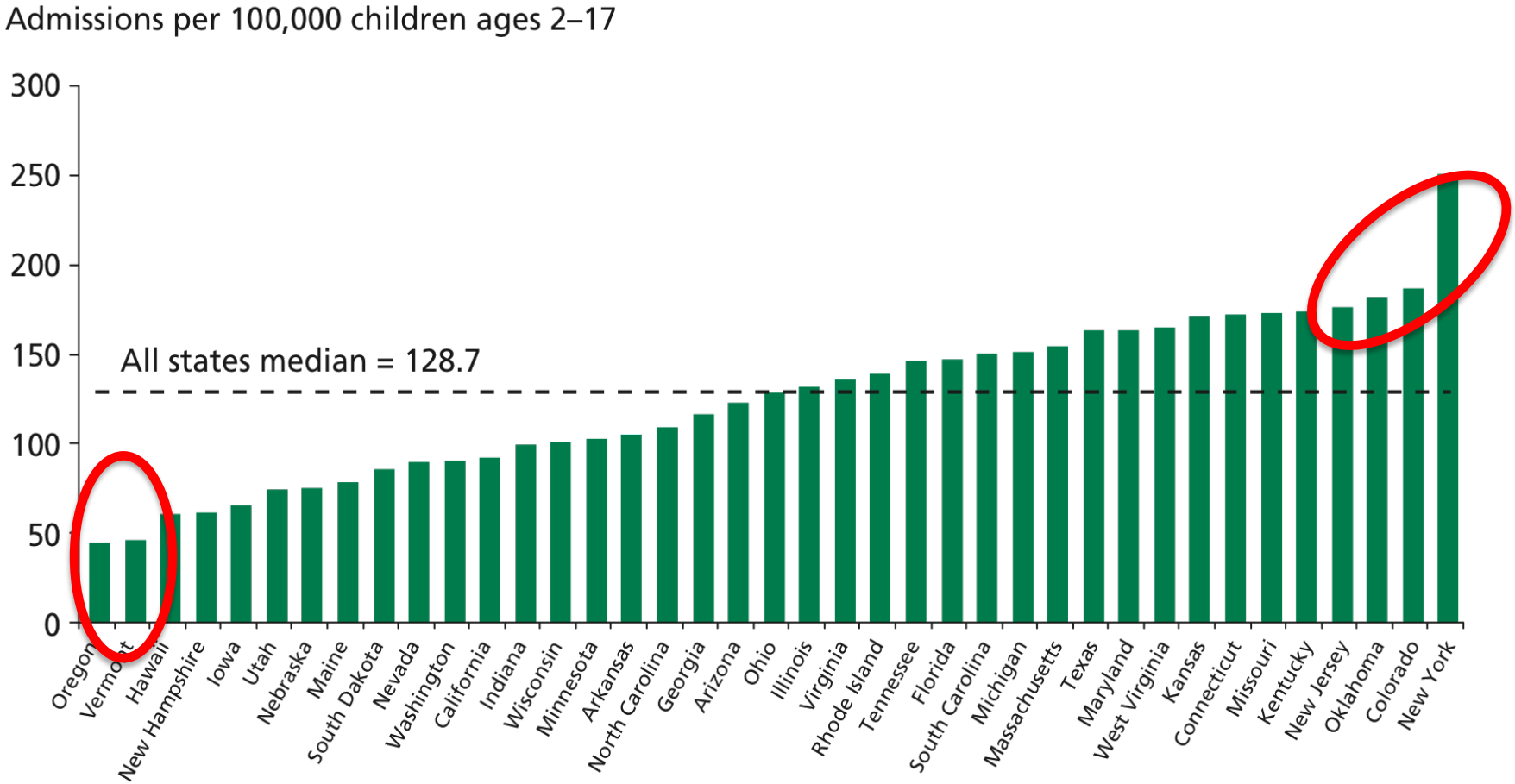


Top 5 states

Children with a medical home	Young children (ages 19–35 months) received six vaccines	Children with preventive medical care visits	Children with preventive dental care visits
1. New Hampshire	1. Iowa	1. Rhode Island	1. Hawaii
2. Nebraska	2. Tennessee	2. District of Columbia	2. Rhode Island
3. Vermont	3. Massachusetts	3. Massachusetts	3. Vermont
4. Iowa	4. Michigan	4. New York	4. Connecticut
5. Massachusetts	5. Louisiana	5. Connecticut	5. Iowa
5. Ohio			

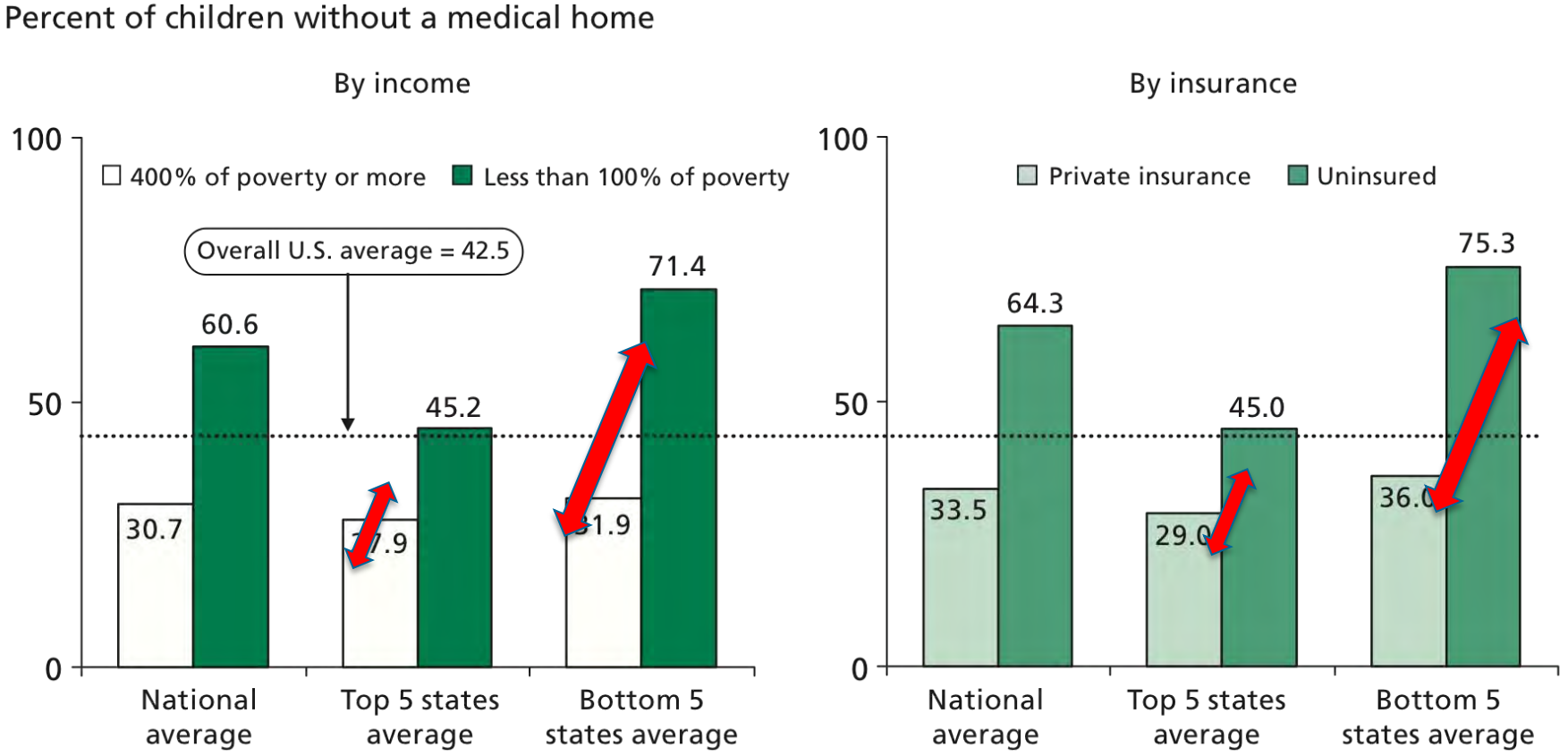
Data: Medical home—2007 National Survey of Children's Health; Vaccines—2009 National Immunization Survey; Medical and dental preventive care visits—2007 National Survey of Children's Health.
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2011.

State Rates of Hospital Admissions for Asthma Among Children, 2006



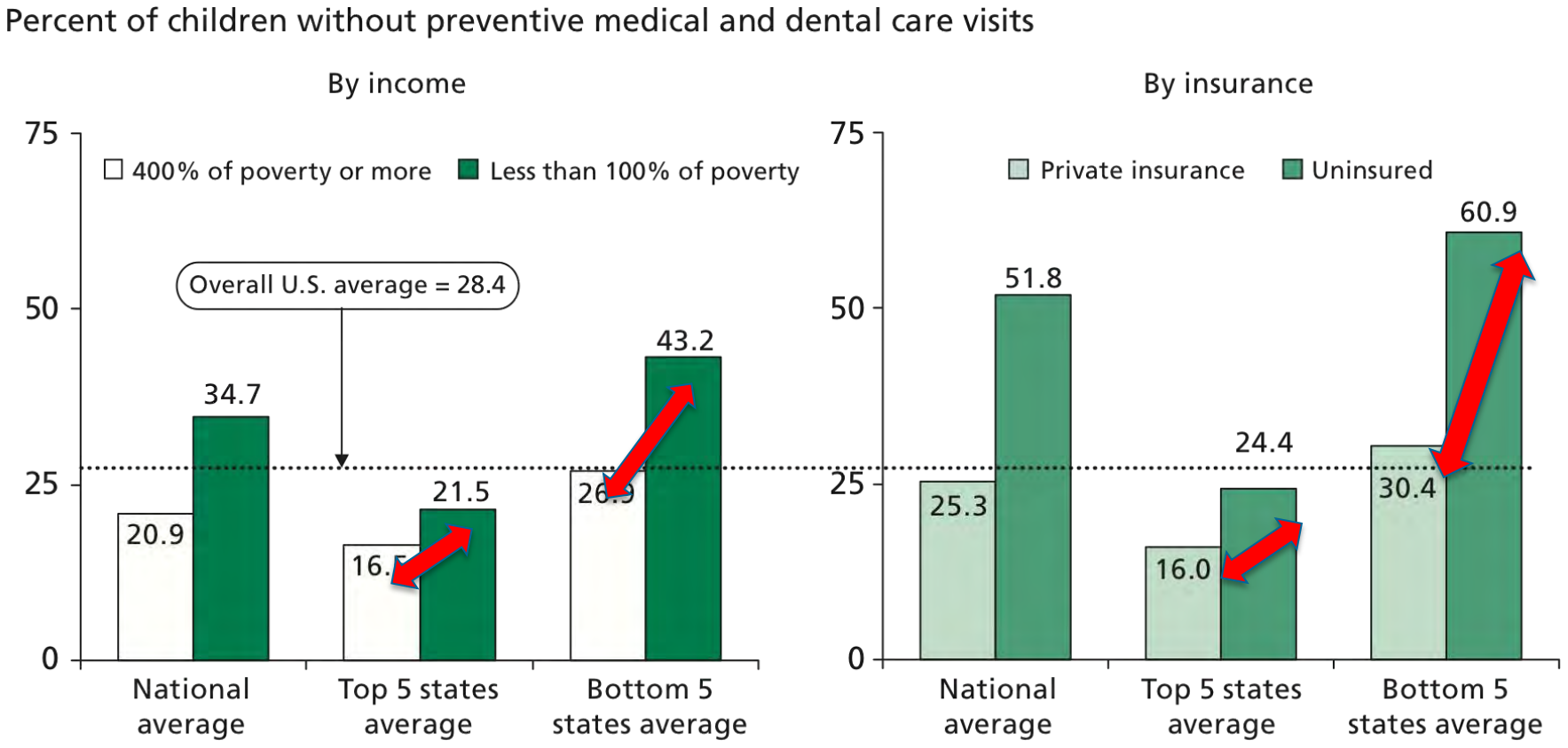
Data: 2006 Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (AHRQ, HCUP-SID 2006); not all states participate in HCUP.
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2011.

Children Without a Medical Home by Income and Insurance



Note: Top 5 states refer to states with smallest gaps between overall U.S. average and low-income/uninsured groups.
Bottom 5 states refer to states with largest gaps between overall U.S. average and low-income/uninsured groups.
Data: 2007 National Survey of Children's Health.
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2011.

Children Without Both Preventive Medical and Dental Visits by Income and Insurance



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Data: 2007 National Survey of Children's Health.
Source: Commonwealth Fund State Scorecard on Child Health System Performance, 2011.

Why measure quality in child health care?

- Variation
- Disparities
- Disparities in Disparities

Data are where you start

Outline

Expanding our toolbox for measurement

BCE (Before CHIPRA Era)

- 90% of Medicaid and 100% of CHIP programs using HEDIS or HEDIS lite (MCO only)
- Little federal coordination or investment in pediatric quality measurement OR improvement
- Inconsistent data collected and reported
- Cross-state comparisons limited and difficult

Source: “Understanding the new quality initiatives in CHIPRA.” Georgetown University Center for Children and Families and Cincinnati Children’s Child Policy Research Center. February 2010.

State of Pediatric Measures

- No comprehensive, valid, and reliable set of measures
  - 2011 IOM report indicates current measures are not robust enough to demonstrate whether children receive high-quality care
  - No uniform system for assessing quality for children across states
- Relatively few measures compared to adult portfolios
  - National Quality Measures Clearinghouse lists 215 child measures out of 1733 total measures
  - National Committee for Quality Assurance lists 13 child-specific measures out of 69 total measures (HEDIS)
- No common measures reported across all state Medicaid/CHIP programs
  - Most commonly reported measure is well-child care (42 states)
  - Most measures reported by <20 states

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ACE (After CHIPRA Era)

- Significant investment in child health quality through CHIPRA
- HITECH builds on this
- ACA
  - Extends CHIPRA model to adults in Medicaid
  - Provides additional support for child health improvement

CHIPRA Quality Components

- Quality Demonstration
- Core Measures
- Pediatric Quality Measures Program
- Model Electronic Health Record Format

CHIPRA Quality Demonstration Program

- One of the largest federally-funded efforts to focus on improving child health care
- Focus on five strategies to improve quality
  - Use CMS' core pediatric quality measures (Category A)
  - Promote HIT/EHR (Category B)
  - Implement provider-based models (Category C)
  - Apply model pediatric EHR format (Category D)
  - Other innovative approaches (Category E)

CHIPRA Quality Demonstration Projects by Category: 10 Grantees* Across 18 States

States	Cat. A	Cat. B	Cat. C
Oregon*	x	x	x
Alaska	x	x	x
West Virginia	x	x	x
Maryland*			x
Georgia			x
Wyoming		x	x
Utah*		x	x
Idaho		x	x
Florida*	x	x	x
Illinois	x	x	x
Maine*	x	x, x	x
Vermont		x	x
Colorado*			x
New Mexico			x
Massachusetts*	x		x
South Carolina*	x	x	x
Pennsylvania*	x	x	
North Carolina*	x		x

Pediatric Quality Measures Program Goals

The Secretary shall establish a pediatric quality measures program to:

- Improve and strengthen the initial core set of children's health care quality measures;
- Expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures; and
- Increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

Legislative Guidance

The measures developed under the pediatric quality measures program shall, at a minimum, be:

- Evidence-based and, where appropriate, risk adjusted;
- Designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;
- Designed to ensure that the data required for such measures be collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

Development of AHRQ/CMS PQMP Portfolio

- Anticipate ~42 measures in AHRQ/CMS PQMP portfolio
- Designed for use at multiple levels (practices, hospitals, states)
- Readily available to purchasers (public and private), providers, and consumers alike
- Measures cover a broad range of pediatric care
  - Outpatient, inpatient care
  - Medical, dental, mental health
  - Process, outcome

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What Will the PQMP Mean for Children?

- Jump-start the child health quality field
- Promote transparency, accountability, and integration
- Meet growing demand for off-the-shelf measures for:
  - Quality improvement
  - Public and private performance incentives (P4P, ACOs, and state-level quality initiatives)
  - Public reporting
- Advance pediatric quality of care methods

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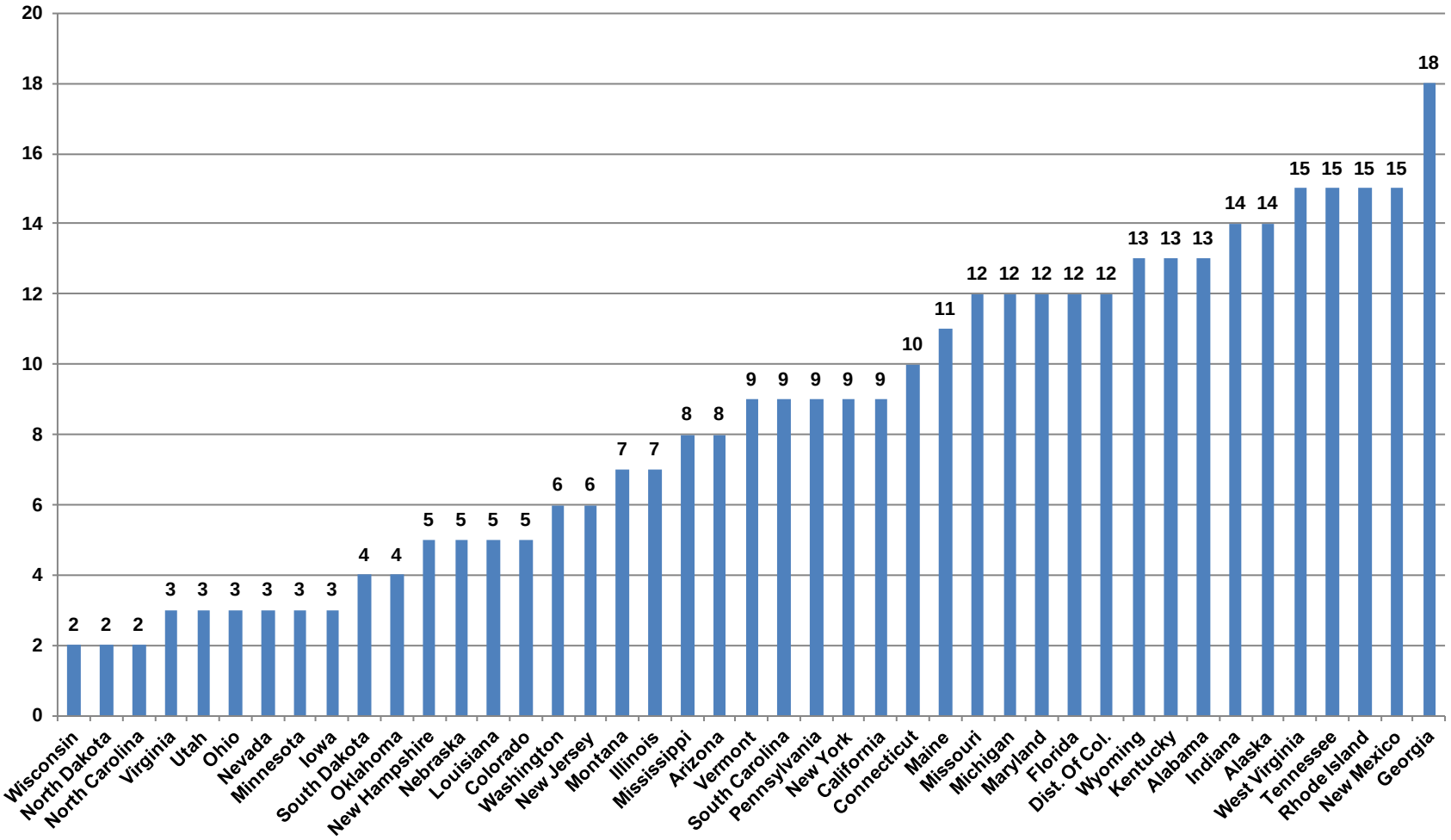
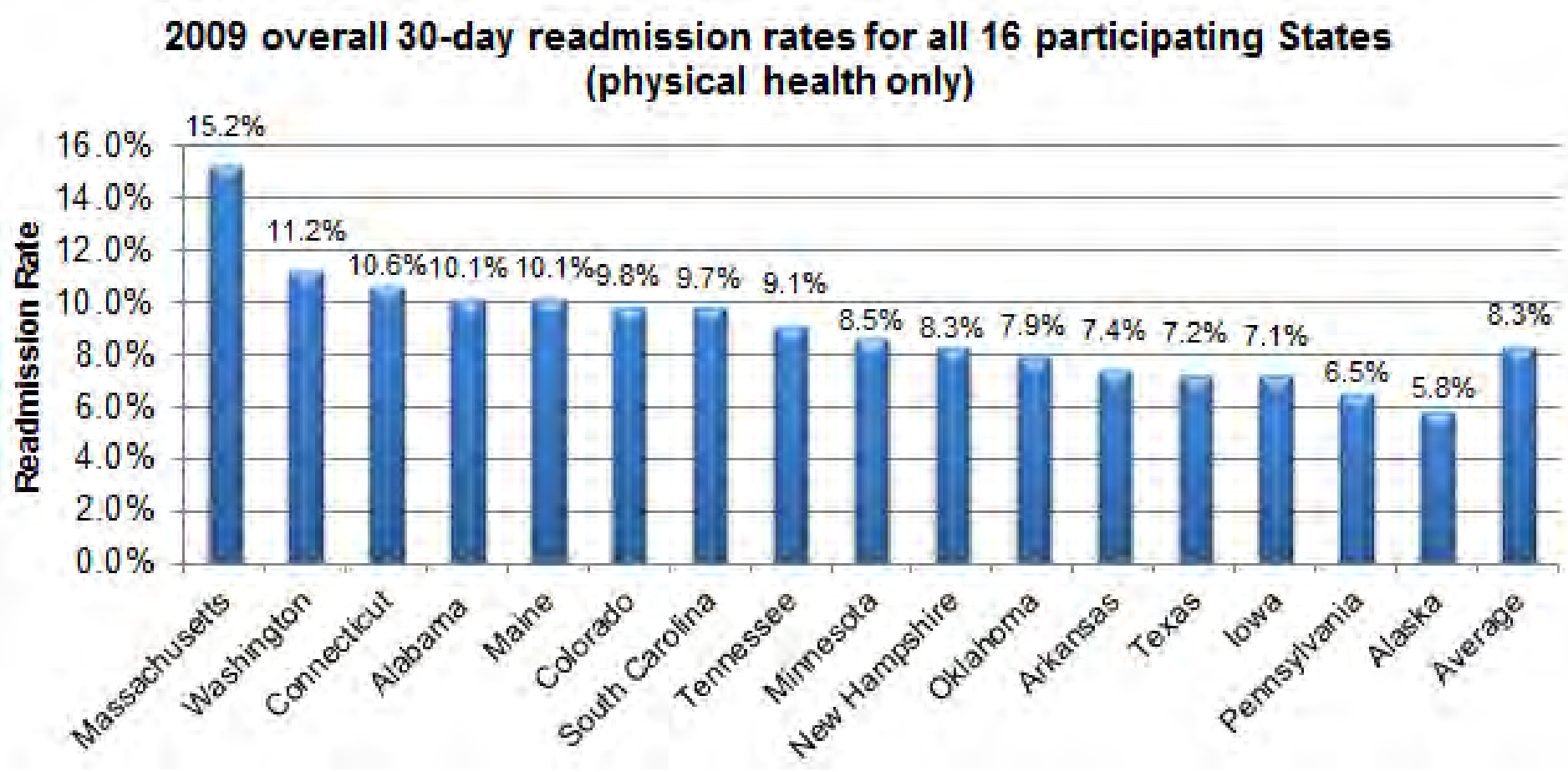
42 States and DC Reported 1 or More Child Health Care Quality Measures in FFY 2010



Notes: Delaware did not submit a CARTS report for FFY 2010. Arkansas, Hawaii, Idaho, Kansas, Massachusetts, Oregon, and Texas submitted FFY 2010 CARTS reports, but did not submit data on any of the children's core quality measures.

Source: Mathematica analysis of FFY 2010 CARTS Reports, as of June 30, 2011.

Knowledge is Power!



Source: AHRQ's Medicaid Medical Directors Learning Network. The views expressed here do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the fact that AHRQ is funding this group imply endorsement of any publications or policy statements that come out from the MMDLN.

But data alone will not be enough…

Outline

Turning measurement into action

The Chain of Effect in Improving Health Care Quality

Environmental context (e.g. policy)

Macro-organization (e.g., health system)

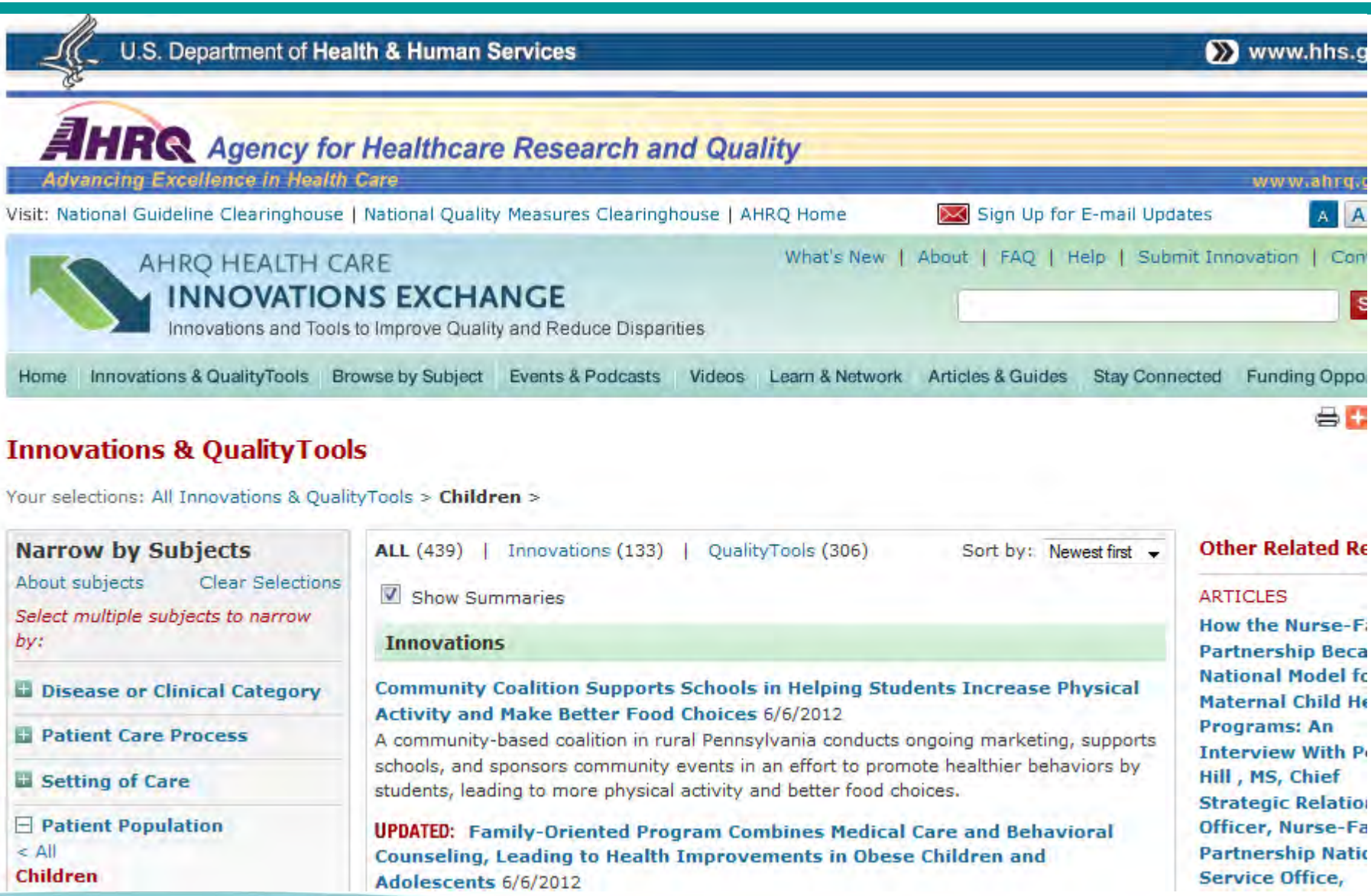
Micro-system of care delivery (e.g., primary care practice)

Child, Family and the Community

The Chain of Effect in Improving Health Care Quality

Measures are used at every level. Improvement and innovation are occurring at every level!

AHRQ Health Care Innovations Exchange on Children

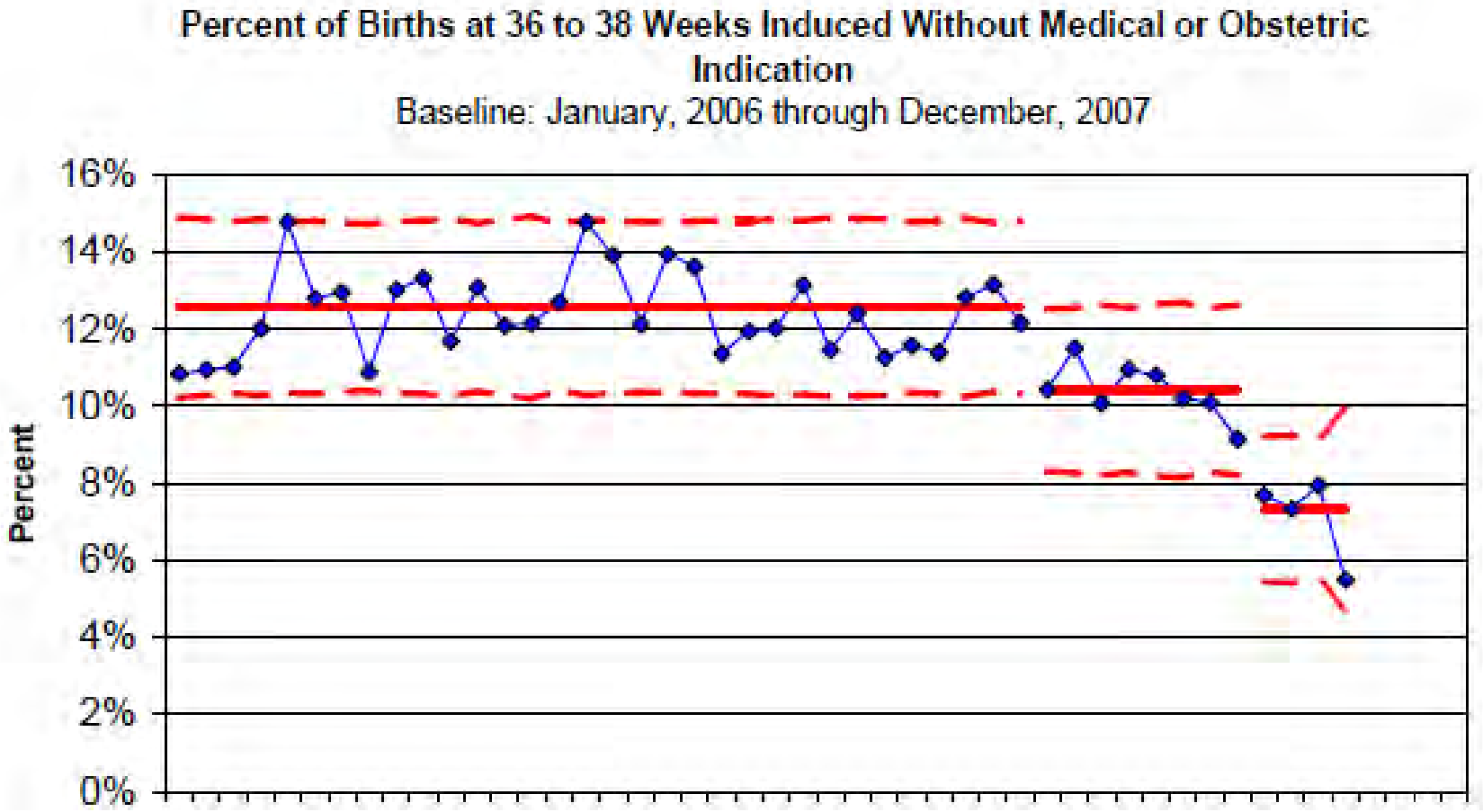


National Initiative for Children's Healthcare Quality

- Sickle Cell Disease Treatment Demonstration Program and Newborn Screening Program
- Applying QI to community and integration of clinical, public health to eliminate childhood obesity
- New York State Breastfeeding Quality Improvement in Hospitals
- Best Fed Beginnings Project

NICHQ National Initiative for Children's Healthcare Quality

Ohio Perinatal Quality Collaborative: Birth Certificate Data for OPQC Hospitals



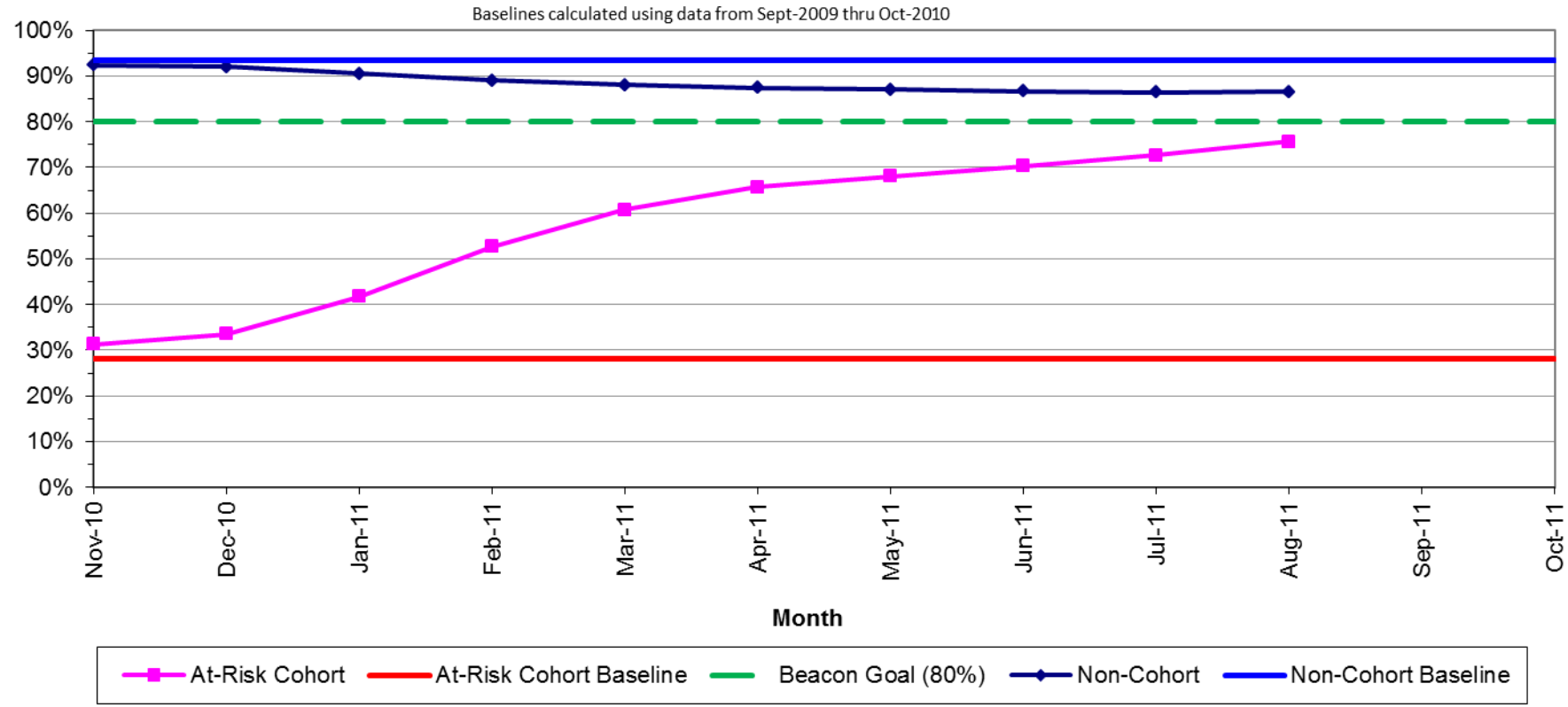
Source: Ohio Perinatal Quality Collaborative

Physician-Hospital Organization Network: Asthma Outcome Measures

Population-Based Measures (Network all-payer asthma population = 12,863)			
	Baseline 8/04 - 7/05	Current 7/10 - 6/11	%Change
% parents missing ≥ 2 work days due to child's asthma over prior 6 months	18.0%	10.2%	43% lower
% parents rating confidence in managing child's asthma < 7/10	11.1%	6.0%	46% lower
% asthma population missing ≥ 2 school days due to asthma over prior 6 months	26.5%	18.6%	30% lower
% activity limitation reported as “not at all” or “a little of the time”	Not captured as these questions were initiated in June 2006	88.5%	n/a
% receiving oral steroids within prior 12 months		19.6%	
% parents rating asthma as “well” controlled		93.3%	
% physicians rating asthma as “well” controlled		89.3%	
% parent and physician agreement on rating degree of asthma control		91.8%	

Keith Mandel, MD; Cincinnati Children’s Hospital Medical Center

Percent of High-Risk vs. Non High-Risk Population with Asthma Control Rated "Well Controlled" by Both Parent and Physician



Cohort population defined using 12 month period from 9/1/2009 through 8/31/2010.

High-risk criteria:

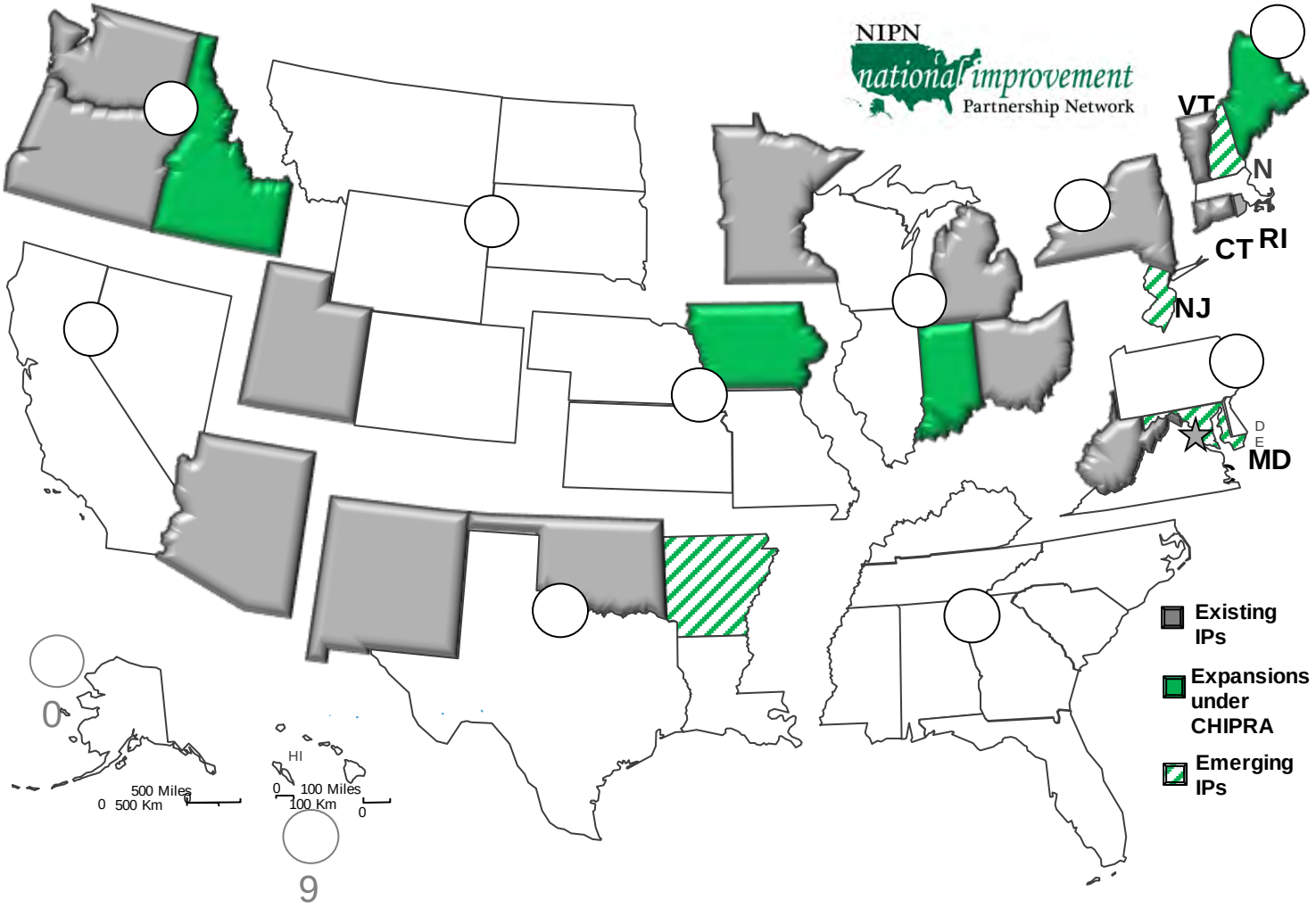
- Severe or moderate persistent asthma.
- "Not well" or "very poorly controlled" asthma (parent or physician rating)
- Activity limitation: "most" or "all" of the time.
- ≥ 1 admit or ≥ 2 ED/urgent care visits or ≥ 2 acute office visits over prior 12 mos.

High-Risk Cohort: n=1,838 (as of 10/11/11)

Cincinnati Children's Hospital Medical Center

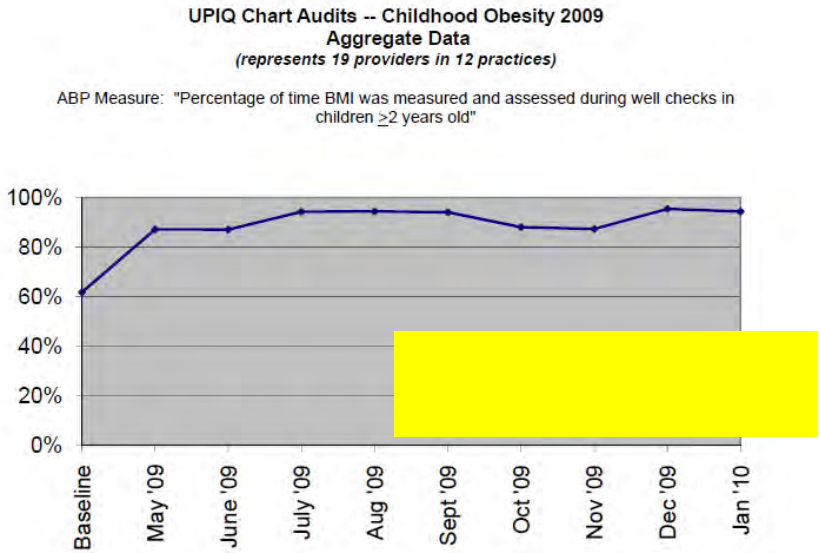
Keith Mandel, MD; Cincinnati Children's Hospital Medical Center

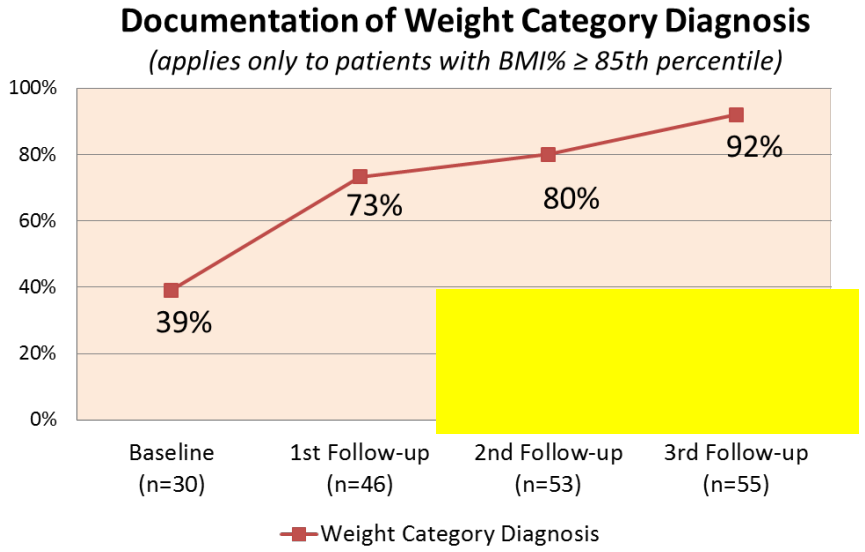
Improvement Partnerships by CMS Region

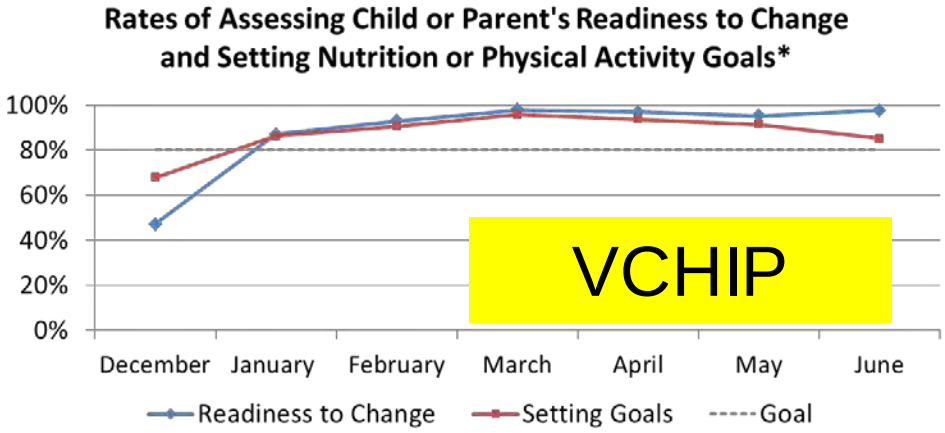


Source: National Improvement Partnership Network

Changes in Practice: Obesity Diagnosis and Treatment







Sources: Utah Pediatric Partnership to Improve Healthcare Quality; Envision New Mexico; Vermont Child Health Improvement Program

Innovative Improvement Projects Under Way (HSR)

Healthy Teen TXT Me:

- Information technology to change teen health behaviors

Teen Mental Health Project:

- Enhanced office care linked to mental health services

Source: AHRQ Innovations Grants On-line Database

Words of Wisdom

"Day after day, in community after community, ingenuity has now taken the ball from theory… It's not just about mandates but about demonstrating, through transparent information on performance and outcomes, that a better approach will serve patients, providers, and payers well."

Outline

Concluding thoughts

Taking it to Scale!

How do we turn multiple single site innovations and successes into large scale, sustainable high performance that improves child health?

Aligning Rewards with Large-Scale Improvement

- “Likelihood of achieving regional, state, or national-level improvement goals is limited without disruptive strategies that accelerate large-scale diffusion of effective interventions.”
- “If success is truly defined as achieving population-based improvement, why not align at least a portion of rewards with achieving this overall aim? Isn’t this a more rational approach?”

Source: Mandel, Keith. “Aligning Rewards with Large-Scale Improvement.” JAMA, February 17, 2010.

The Role of Policy Change

- Remove barriers
- Make the right thing to do the easy thing to do
- Reward both performance AND improvement
- Leverage incentives from other sectors

Children Deserve Our Best

"Somehow, what troubles people isn't so much being average as settling for it.

And so I push to make myself the best.

Whatever the next round of numbers may say."

Source: Gawande, Atul. "The Bell Curve: What happens when patients find out how good their doctors really are?" The New Yorker, December 6, 2004.

Source: Sean Sexton, 2003

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Questions?

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