Leveraging Patient Centered Medical Homes in CHIPRA Quality Demonstration Grants

CHIPRA Demonstration Grantee Webinar Series

August 20, 2013

Massachusetts – Becoming a Medical Home

Utah/Idaho – Improving Continuity of Care

North Carolina – Promoting and Measuring EPSDT

Agenda

- Welcome
- Introductions
- Presentation of State Project Spotlights
  - Massachusetts
  - Utah/Idaho
  - North Carolina
- Questions

Care Coordination in the Pediatric Medical Home Massachusetts' CHIPRA Quality Demonstration Grant

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CHIPRA Grant Project Director

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Learning Collaborative Project Director

Agenda

- Introductions
- MA CHIPRA Quality Demonstration Grant Goals
- Learning Collaborative Goals
- Medical Home Driver Diagram and Care Coordination Measures
- Care Coordination Framework
- Care Planning at the Demonstration Practices
- Questions

Massachusetts' CHIPRA Quality Grant Goals

Support the development and maintenance of an integrated approach to measurement and improvement across all settings of child health care delivery that will lead to transformational gains in children's health and outcomes through:

- Child Core measures reporting to practices and families
- Medical home transformation support and spread efforts
- Creation of the MA Child Health Quality Coalition

Spotlight Grant Activity: Medical Home Learning Collaborative

Mission

Transform care for children and families at participating practices so that:

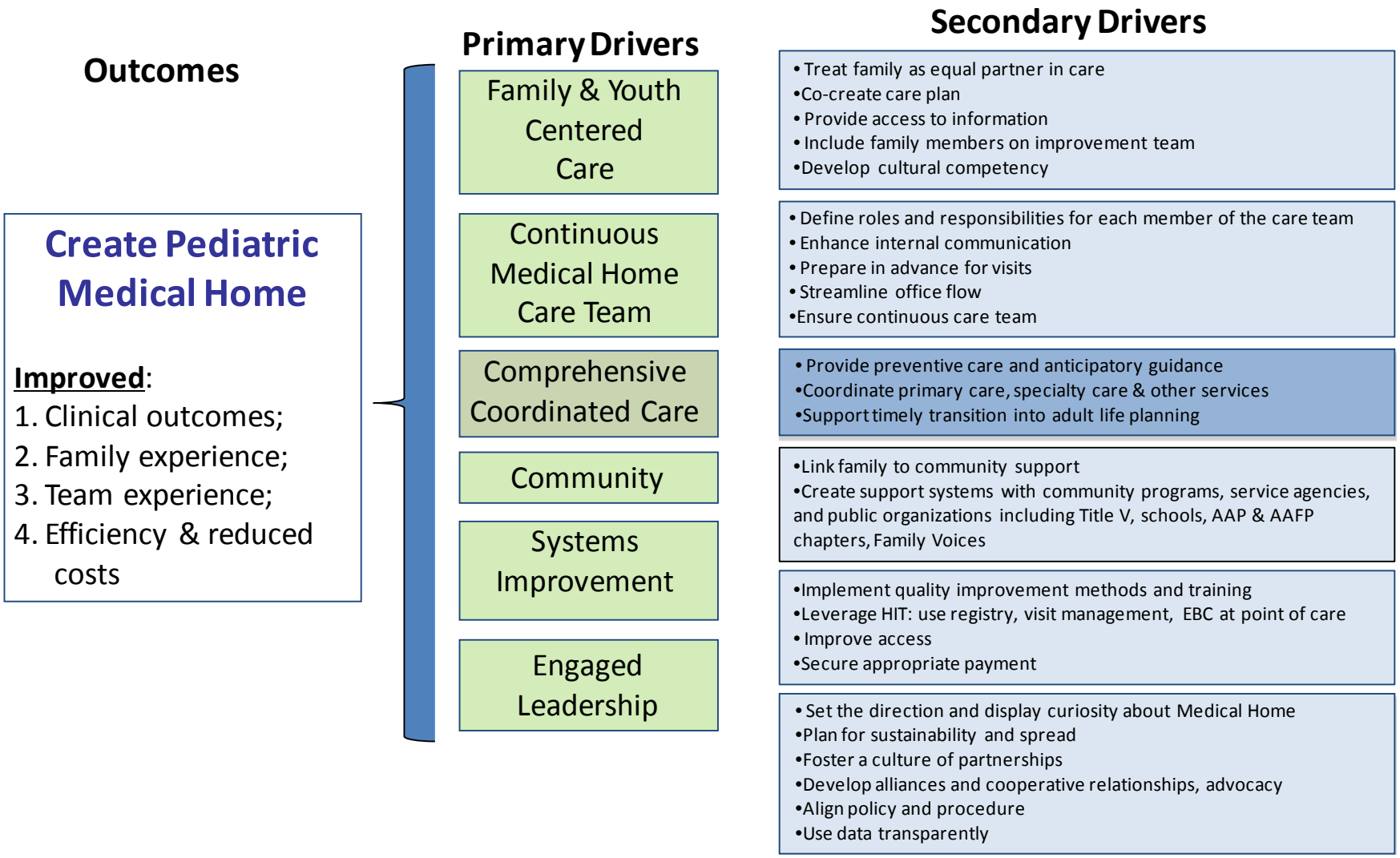
- Care is coordinated
- Children and their families are supported as decision makers
- Community resources and specialty, behavioral, and oral health providers are integrated

Spotlight Grant Activity: Medical Home Learning Collaborative

Goals

- Demonstrate significant improvements in care and outcomes
- Establish effective models for tracking data to measure improvements and determine priority changes
- Improve team development
- Establish a basis for widespread dissemination and uptake of improved approaches to care
- Demonstrate measureable improvements in comprehensive well care, developmental health, mental and oral health, clinical outcomes, patient safety, care planning, transition to adulthood, efficiency, and medical home transformation

CHIPRA Learning Collaborative Driver Diagram



Measures of Care Planning and Care Coordination

- Percentage of patients that need a care plan who have one
  - Children with special healthcare, behavioral health, and/ or social needs
  - Comprehensive approach to care planning: strengths-based approach, included demographic, medical, social info as well as self-management goals
  - Updated every 6 months
  - Patients identified using registry (initial system was provider referral at most sites)
    - Create registry using ICD-9 codes, HOMES index, CAMHI screener

Measures of Care Planning and Care Coordination

- Percentage of patients who need a care plan who have evidence of a transition plan by age 13
- Percentage of patients who have a care plan who have had it updated within last 6 months
- Percentage of patients with a positive developmental/ behavioral screen that have evidence of a report from referral service provider within 3 months after positive screen

Care Coordination Framework

Key elements of high-performing pediatric care coordination building (five domains):

1. Needs assessment for care coordination and continuing care coordination engagement
2. Care planning and communication
3. Facilitating care transitions (inpatient, ambulatory)
4. Connecting with community resources and schools
5. Transitioning to adult care

Importance of Care Coordination

- Identify and document medical and social needs
- Promote effective collaboration with specialists and community supports
- Document family centered goals for care team and family
- Identify opportunities for systems improvement that are family centered – opportunity for direct family feedback

Addressing Medical and Social Needs

- Care coordinator/social worker helped family get access to safe, healthy housing
- Care coordinators/social workers assisted families with completing forms, submitting requests for services, and identifying resources
- Care team helped family obtain legal guardianship of terminally ill patient when she turned 18 and wrote letters to try to help family living abroad get visas to visit her
- During transition planning meeting with patient, provider reviewed legal and vocational resources in addition to medical documents

Effective Collaboration: Specialists and Community Organizations

- Care team (including PCP, nurse, care coordinator, parent, MASSTART* nurse) scheduled a call with specialists to discuss patient's condition
- Care team connected with Knights of Columbus to install ramp for wheelchair-dependent patient
- Care team notified utility companies, police and fire department about patient who is technology dependent so they ensure her safety during emergencies

*MASSTART: Massachusetts Technology Assistance Resource Team

Using Care Plans to Identify and Track Family Goals

- Care plan creation helps identify social needs
- Creation of care plans engages families in care
- Obesity care plan encourages providers to assess patient motivation and provide more comprehensive treatment/follow-up
- Patient used asthma plan to achieve goal of avoiding ER

Care Coordination
Supporting Broader Patient Centered Medical Home (PCMH) Transformation Goals

The changes made within care coordination and systems improvement have helped:

- Engage and motivate patients and families
- Clearly define team roles
- Allow staff to be more accessible and knowledgeable
- Gain buy-in and support from leadership
- Improve efficiency and effectiveness of care

Questions?

Improving Continuity of Care for Children and Youth with Special Health Care Needs in a PCMH

Jason Fox
Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ)

Gina Pannell
Idaho Health and Wellness Collaborative for Children (IHAWCC)

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CHIC Partners

- Utah Department of Health / Utah Medicaid Program
- Idaho Department of Health and Welfare / Idaho Medicaid Program
  - University of Utah Health Sciences Center
  - Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ)
  - Idaho Health and Wellness Collaborative for Children (IHAWCC)

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Agenda

- Introductions
- Utah/Idaho CHIPRA Quality Demonstration Grant Goals
- Overview of Strategies to Improve Care for Children with Special Health Care Needs
  - Utah - Self-care plan project
  - Idaho - Improving referrals to specialists
- Questions

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CHIC Goals

- Category B – Promote the Use of HIT in Children's Health Care Delivery
- Category C – Evaluate a Provider-Based Model that will Improve Children's Healthcare Delivery
  - Develop the infrastructure needed to support "embedded" care coordinators in participating practices
  - Implement and evaluate a Medical Home demonstration with care coordination, parent partners, and quality improvement as key components
- Category E – Develop a State/Regional Model for a National Quality System

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CHIC Medical Home Demonstration - Utah

- 12 Pediatric Practices; 3 ½ years
  - 9 Pediatric Primary Care
  - 3 Pediatric Sub-Specialty
- Sequential 9-month learning collaboratives
  - Referral processes
  - Care plans and Self-care plans
  - Transitions (to adult care model, from mental health, between inpatient and outpatient)
- Interim optional 3-month projects at individual practice level

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Spotlight Grant Activity: Self-Care Plan Collaborative – Utah

Areas of Focus

1. Creating a Self-Care Plan for an identified population of Children with Special Health Care Needs (CSHCN) [e.g., Attention-Deficit/Hyperactivity Disorder (ADHD), Asthma, Level 3 CSHCN]
2. Involving families in developing Self-Care Plans
3. Following up with patients based on recommendations in the Self-Care Plan

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Self-Care Plan Collaborative – Utah

Evidence of a Self-Care Plan	Baseline	Post
Primary-Care Practices	0%	67%
Pediatric Subspecialties	67%	99%

Evidence of Family Involvement	Baseline	Post
Primary-Care Practices	0%	55%
Pediatric Subspecialties	18%	99%

Evidence of Appropriate Follow-Up	Baseline	Post
Primary-Care Practices	0%	57%
Pediatric Subspecialties	6%	99%

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Self-Care Plan Collaborative – Utah

1. Create a Self-Care Plan for a population of CSHCN
   - Practices implemented both paper-based and Electronic Medical Record (EMR)-based
     - Asthma action plans
     - Initial and follow-up self-care plans for ADHD
     - Self-care plans for key complex conditions

Lessons Learned:

- EMR integration of self-care plans can be challenging
- Gaining consensus from all providers can be difficult
- PDSAs need to start early with a structure/template

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Self-Care Plan Collaborative – Utah (cont'd)

2. Involve families in developing Self-Care Plans
   - Practices incorporated parents/families in developing paper or EMR-based action plans and care-plans
   - Practices created EMR templates/hot-texts to note parent/family involvement during the visit

Lessons Learned:

- A signature line and/or text in an EMR template does not necessarily reflect meaningful family involvement
- PDSAs need to focus on the HOW or PROCESS for actively involving patients and families in self-care plans

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CHIC Self-Care Plan Collaborative – Utah (cont'd)

3. Follow-up with patients based on recommendations in the Self-Care Plan
   - Practices standardized follow-up visits for:
     - asthma exacerbations
     - ADHD
     - chronic disease management

Lessons Learned:

- Follow-up can be standardized and built into work-flow; requires the whole team being on the same page
- Plan-Do-Study-Act Cycles need to involve the entire team: front-desk staff working with Medical Assistant/Care Coordinator working with provider

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CHIC Self-Care Plan Collaborative – Utah (cont'd)

Another key lesson

- Family Partners can be a valuable resource – utilize them!

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Spotlight Grant Activity: Improving Referrals for Children with Developmental Needs - Idaho

- Goals of Pilot:
  - Improve communication between PCP and family regarding developmental/behavioral concerns and referral to a specialist
  - Improve the quality/appropriateness of the referral
  - Improving the wait time from date of referral to appointment with specialist
  - Improve referral follow-through
- Activities
  - Determined PCP and specialist concerns
  - Reviewed current process and made process changes
  - Implement new process
  - Evaluate

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Identification of Concerns

Concerns	Specialist Concerns	PCP	Patient/ Family
Length of time for completed evaluation	X	X	X
Confusing steps in order to access Specialty Clinic (SC)			X
PCP has vested interest in the patient, not the Specialist	X	X	
Lack of referral follow-through	X	X	
Length of time to receive intake packet and schedule appointment once referred	X		X
Time spent/lack of process attempting to contact patients	X		X
Receiving inappropriate/non-specific referrals	X		
Families lack of understanding/need for referral	X	X	X

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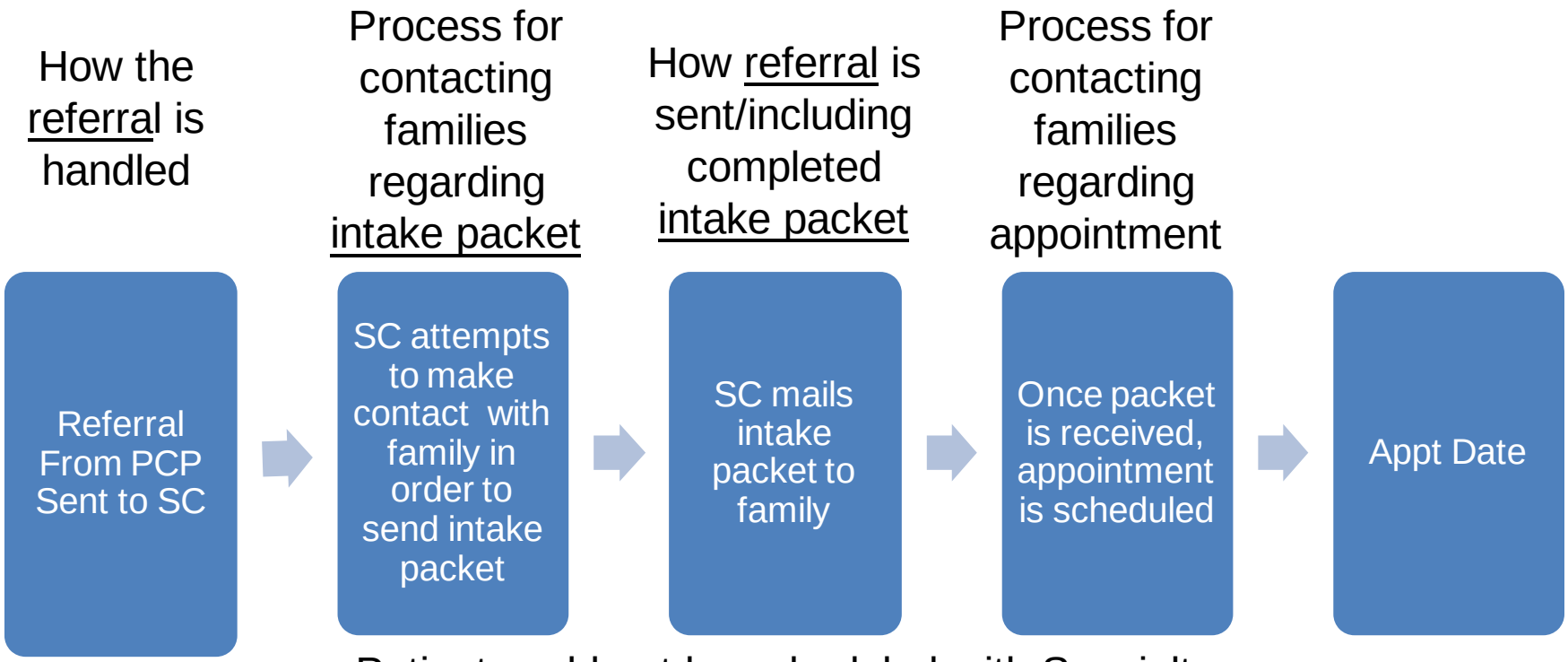
Review of Process/What Can We Control?



Patient could not be scheduled with Specialty Clinic until intake packet and referral were received.

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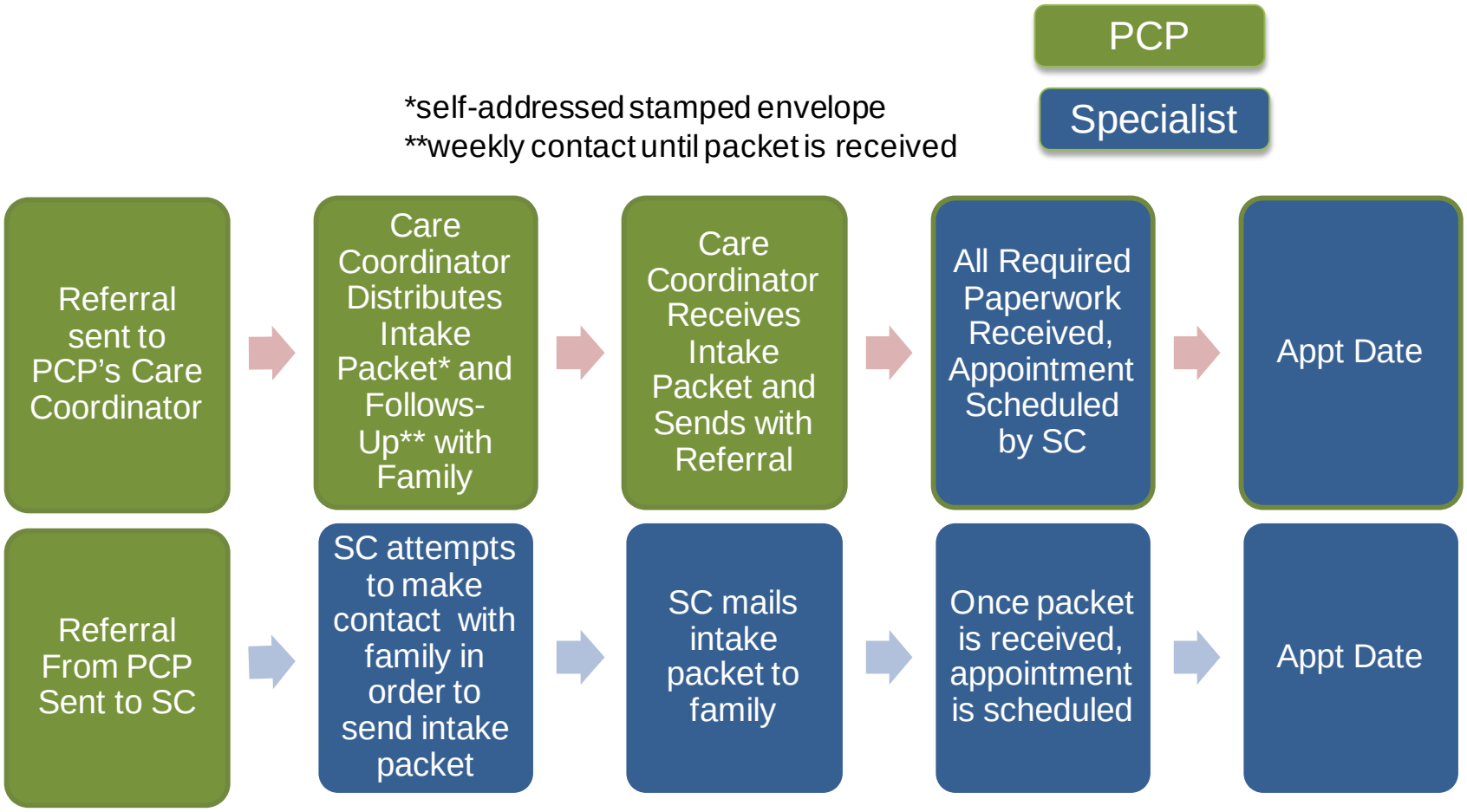
What Can We Change?



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Improve Referral Process

Results

Pre

Patient	Days to Appt
Patient A	No appt
Patient B	No appt
Patient C	148
Patient D	113
Patient E	98
Patient F	No appt
Patient G	No appt
Patient H	219
Patient I	149
Patient J	No appt
Average wait time	145 days
% seen by specialist	50%

Post

Patient	Days to Appt
Patient AA	120
Patient BB	139
Patient CC	143
Patient DD	101
Patient EE	112
Patient FF	112
Patient GG	142
Patient HH	175
Patient II	101
Patient JJ	Declined services
Average wait time	127 days
% seen by specialist	90%

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Lessons Learned to Date

- Improving continuity of care for CSHCN requires evaluation of current processes on both sides of the referral
- Both clinics must allocate resources to provide for workload adjustments to improve effectiveness and efficiency
- Replication of this QI referral project with other Pediatric Specialists may yield similar results
- CSHCN experienced a significant improvement in accessing care with minimal impact on both PCP and Specialty Clinics on actual time spent making adjustments

Utah and Idaho
Children's Healthcare Improvement Collaboration (CHIC)

Questions?

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CHIPRA Quality Demonstrations
Strengthening the Quality of Children's Health Care

Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Population Management and Quality Improvement

Marian Earls, MD, FAAP
Lead Pediatric Consultant
Community Care of North Carolina

Agenda

- Welcome and Introductions
- Background
- Overview of Strategies
- Questions

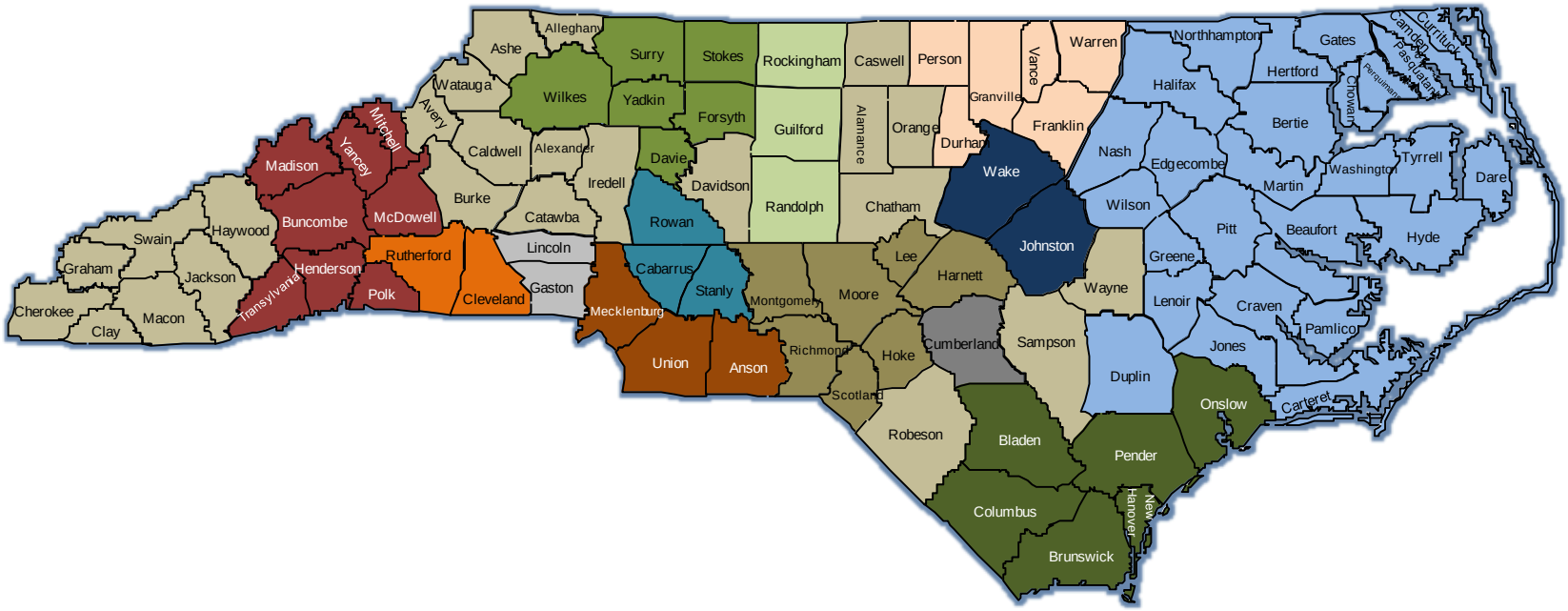
North Carolina's CHIPRA Quality Grant Goals

Quality Goals – 5 major areas: EPSDT, Developmental/ Behavioral/Social-Emotional, Oral Health, Obesity and Asthma

- Integrate Child Core Quality Measures with CCNC's routine quarterly reporting
- Go beyond annual reporting to CMS to more real-time reporting at the practice and network level and use data for quality improvement
- To establish a model of practice support in every network through Pediatric Quality Improvement Specialists
- To align Pediatric Electronic Health Record (PEHR) format implementation with CCNC Pediatric Quality Priorities and Quality Improvement Activity
- To develop eMeasures for practice use and Health Information Exchange (HIE)

Community Care of North Carolina (CCNC)

- 14 Networks representing all 100 counties
- Statewide medical home and care managed system to address quality, utilization and cost
- Created a data driven infrastructure
- Facilitates Medicaid savings achieved through partnership with doctors, hospitals and other providers with 100% of savings remaining in the State



CHIPRA Quality Demonstrations
Strengthening the Quality of Children's Health Care

Moving the Needle
North Carolina's Statewide Approach

- Quarterly Data via CCNC's Informatics Center
- 0.5 time Quality Improvement Specialist (QIS) at each Network
- Quality Improvement 101 Training for all QIS
- Monthly Clinical Content training sessions on all Core Quality Measures
- Technical Assistance from the CHIPRA team

Spotlight Grant Activity: Improving EPSDT Performance

EPSDT Practice Profile

- Provide a quarterly profile of EPSDT and its components as part of CCNC's routine reporting to practices and networks
- Supported by pediatric Quality Improvement Specialists
- Measures
  - Well child visits (all ages 0-20)
  - Vision and Hearing
  - BMI percentile
  - Developmental and Behavioral Screening (all ages 0-20)
  - Annual Dental Visit and Dental Varnishing (6-66 months)
- Sample data

EPSDT Practice Profile
Well Visits – 7 to 11 and Adolescents

7 to 11 Years of Life Well-Care	Year Ending	Eligible Patients	Patients with a Visit	% of Patients with a Visit
NETWORK	Mar 2013	6521	3407	**52%**
NETWORK	Mar 2012	5685	2686	**47%**
CCNC TOTOAL	Mar 2013	163226	76860	**47%**
CCNC TOTAL	Mar 2013	140159	66546	**48%**
Best Network Performance	Mar 2013	.	.	**53%**

Adolescent Well-Care	Year Ending	Annual Well-Care (12-21)			Well-Care in Past 3 Years (12-21)		
		Eligible Patients	Patients with a Visit	% of Patients with a Visit	Eligible Patients	Patients with a Visit	% of Patients with a Visit
NETWORK	Mar 2013	8405	3759	**45%**	6388	4904	**77%**
NETWORK	Mar 2012	7481	3095	**41%**	5704	4149	**73%**
CCNC TOTOAL	Mar 2013	190924	83400	**44%**	141670	109997	**78%**
CCNC TOTAL	Mar 2013	161777	69989	**43%**	125853	95796	**76%**
Best Network Performance	Mar 2013	.	.	**49%**	.	.	**83%**
HEDIS Mean 2011	.	.	.	**50%**	.	.	.
HEDIS 90th Percentile 2011	.	.	.	**65%**	.	.	.

EPSDT Practice Profile
Screening Measures

ABCD/Development & MCHAT/Autism Screening	Year Ending	ABCD/Developmental (6-66 months)			MCHAT/Autism (18-30 months)		
		Well-Check Visits	Visit with Screening	Screening Percent	Well-Check Visits	Visit with Screening	Screening Percent
NETWORK	Mar 2013	11306	9396	**83%**	3481	2527	**73%**
NETWORK	Mar 2012	10587	8873	**84%**	3338	1920	**58%**
CCNC TOTAL	Mar 2013	277405	191136	**69%**	81512	44421	**55%**
CCNC TOTAL	Mar 2012	270391	199640	**74%**	80720	36963	**46%**
Best Network Performance	Mar 2013	.	.	**83%**	.	.	**73%**

Development and Behavioral Screening	Year Ending	School Age (6-10)			Adolescent (11-20)		
		Well-Check Visits	Visit with Screening	Screening Percent	Well-Check Visits	Visit with Screening	Screening Percent
NETWORK	Mar 2013	3835	1380	**36%**	3920	1310	**33%**
NETWORK	Mar 2012	3055	513	**17%**	3341	467	**14%**
CCNC TOTAL	Mar 2013	85401	8822	**10%**	91519	10610	**12%**
CCNC TOTAL	Mar 2012	76895	4487	**6%**	80221	5865	**7%**
Best Network Performance	Mar 2013	.	.	**36%**			**33%**

EPSDT Practice Profile
Network and Practice Rates

Practice	Year Ending	1056ABCD/Developmental (6 months – 66 months)			MCHAT/Autism Screening (18 moths – 30 months)		
		Well-Check Visits	Visits with Screening	Screening Percent	Well-Check Visits	Visits with Screening	Screening Percent
n3cn	Dec 2012	7956	7042	**89%**	2579	1845	**72%**
A Brighter Future Healthcare	Dec 2012	6	0	**0% ***	2	1	**50% ***
All American Pediatrics	Dec 2012	437	410	**94%**	150	95	**63%**
Calvary Pediatrics	Dec 2012	900	562	**62%**	316	120	**38%**
Cape Center Pediatrics	Dec 2012	519	499	**96%**	188	188	**100%**
Carolina Pediatric Group, PA	Dec 2012	448	384	**86%**	123	50	**39%**
Chander K. Gupta, Pediatric Clinic	Dec 2012	39	26	**67%**	12	2	**17% ***
Cross Creek Pediatrics	Dec 2012	241	187	**78%**	84	72	**86%**
Cumberland Children's Clinic	Dec 2012	599	515	**86%**	803	190	**91%**
Cumberland Family Practice	Dec 2012	.	.	.		.	.
Eastover Family Care	Dec 2012	6	2	**33% ***	2	1	**50% ***
Fayetteville Children's Clinic	Dec 2012	172	134	**78%**	35	29	**81%**
Hope Mills Pediatrics	Dec 2012	929	874	**94%**	329	286	**87%**
Legacy Pediatrics	Dec 2012	343	326	**95%**	103	94	**87%**
Northside Pediatrics	Dec 2012	640	611	**96%**	190	142	**75%**
Owen Drive Children's Clinic	Dec 2012	435	434	**100%**	125	47	**37%**
Owen Park Pediatrics, PA	Dec 2012	253	231	**91%**	75	53	**70%**
Prime Pediatrics	Dec 2012	239	220	**92%**	61	49	**80%**
Rainbow Pediatrics of Fayetteville	Dec 2012	1046	968	**93%**	381	283	**74%**

EPSDT Practice Profile
Oral Health and BMI Measures

Annual Dental Visit	Year Ending	Ages 2 to 3		Ages 4 to 6		Ages 7 to 14		Ages 15 to 21		Ages 2 to 21	
		Eligible Pts	%	Eligible Pts	%	Eligible Pts	%	Eligible Pts	%	Eligible Pts	%
NETWORK	Mar 2013	4148	45%	5766	68%	10017	70%	4836	56%	24767	63%
NETWORK	Mar 2012	3648	44%	4982	68%	8837	68%	4301	55%	21768	61%
CCNC TOTAL	Mar 2013	104106	44%	149939	66%	247963	68%	104773	56%	606781	61%
CCNC TOTAL	Mar 2012	94859	43%	131078	67%	211017	69%	90221	56%	527175	62%
Best Network Performance	Mar 2013	.	52%	.	70%	.	71%	.	61%	.	68%

Dental Topical Fluoride Varnishing	Year Ending	Eligible Patients	3 or more Varnishings	3 or more Varnishings Percent	4 or more Varnishings	4 or more Varnishings Percent
NETWORK	Mar 2013	1291	532	41%	359	28%
NETWORK	Mar 2012	1196	435	36%	291	24%
CCNC TOTAL	Mar 2013	36409	21115	58%	15715	43%
CCNC TOTAL	Mar 2012	33185	18324	55%	13407	40%
Best Network Performance	Mar 2013	.	.	69%	.	58%

Body Mass Index	Year Ending	BMI (3-20)		
		Eligible Patients	Patients with Screening	Screening Precent
NETWORK	Mar 2013	18351	8029	44%
NETWORK	Mar 2012	15730	1824	12%
CCNC TOTAL	Mar 2013	453208	56700	13%
CCNC TOTAL	Mar 2012	392712	15601	4%
Best Network Performance	Mar 2013	.	.	44%

Spotlight Grant Activity: Population Management

Population Management Necessary for Effective Quality Improvement

- Goal is to use population management at the network (macro) and practice (micro) levels
- Identifies specific population in order to use targeted strategies for improved outcomes
- BMI percentile (obesity); Foster Care; Sickle Cell; Asthma

Population Management
BMI Percentage by V-Codes and Age Groups

BMI V Code Used	Age: 3 – 5 years		Age: 6 – 10 years		Age: 11 – 20 years		Total	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
V85.51	547	3%	314	2%	320	2%	1181	2%
V85.52	11844	67%	8037	55%	7420	48%	27301	57%
V85.53	2317	13%	2120	15%	2533	16%	6970	15%
V85.54	3038	17%	4090	28%	5133	33%	12261	26%
CCNC Total	**17746**	.	**14561**	.	**15406**	.	**47713**	.

Population Management: One Network Example of Practices with Highest Foster Care Populations

Network Name	Provider Name	Foster Care Count
Community Care Partners of Greater Mecklenburg	Charlotte Pediatric Clinic	221
Community Care Partners of Greater Mecklenburg	Teen Health Connection	151
Community Care Partners of Greater Mecklenburg	CMC Myers Park Pediatric Clinic	22
Community Care Partners of Greater Mecklenburg	Center for Child & Adolescent Medicine	16
Community Care Partners of Greater Mecklenburg	North Charlotte Pediatrics	15
Community Care Partners of Greater Mecklenburg	CMC NorthPark	13
Community Care Partners of Greater Mecklenburg	Union Pediatrics	10
Community Care Partners of Greater Mecklenburg	Starks Pediatrics at Mallard Creek	10
Community Care Partners of Greater Mecklenburg	Grace Pediatric Clinic	10

Population Management
Foster Care vs. Non-Foster Care

Foster Care vs. Non-Foster Care Rates for:

- Asthma
- ADHD
- Mental Health
- Developmental Disability
- Emergency Department Visits
- PMPM (Per member per month cost)

.	Asthma [AS1]		ADHD [AD]		Mental Health [MH]		Developmental Disability [DD]		Emergency Department Visits [EDVIS				PMPM	Total # of Kids
									1 Visit		2+ Visits			
.	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Count*	*Percent*	*Cost*	*Count*
Foster Care	955	13%	1863	25%	4062	55%	1389	19%	1644	22%	1139	15%	$1060.35	7431
Non-Foster Care	118291	10%	92953	8%	176930	16%	61349	5%	219429	19%	132324	12%	$227.89	1136236
CCNC Overall	119246	10%	94816	8%	18092	16%	62738	5%	221073	19%	133462	12%	$233.46	1143667

Population Management
Sickle Cell – Number of Patients per Network

.	Sickle Cell Patients			
Network	**Total**	**Age: 0-14**	**Age: 15-20**	**Age: 21+**
ACCESSCARE	214	120	28	66
CAROLINA COLLABORATIVE COMMUNITY CARE	140	61	20	59
CAROLINA COMMUNITY HEALTH PARTNERSHIP	33	19	3	11
COMMUNITY CARE OF EASTER CAROLINA	448	174	54	220
COMMUNITY CARE OF SOUTHERN PIEDMONT	78	40	12	26
COMMUNITY CARE OF THE LOWER CAPE FEAR	143	58	20	65
COMMUNITY CARE OF THE SANDHILLS	148	52	25	71
COMMUNITY CARE OF WAKE AND JOHNSTON	330	128	35	167
COMMUNITY CARE OF WESTERN NORTH CAROLINA	27	16	4	7
COMMUNITY CARE PARTNERS OF GREATER MECKLENBURG	434	208	62	164
COMMUNITY HEALTH PARTNERS	41	20	3	18
NORTHERN PIEDMONT COMMUNITY CARE	163	63	17	83
NORTHWEST COMMUNITY CARE	160	69	27	64
PARTNERSHIP FOR HEALTH MANAGEMENT	153	86	28	39
CCNC TOTAL	**2512**	**1114**	**338**	**1060**

How the Needle has Moved

Quarterly EPSDT Pediatric Profiles Rates – CCNC Totals				CHIPRA Begins	2010 Baseline rate vs. current rate
.	Mar-13	Dec-12	Dec-11	Dec-10	Variance
15 month WCV – six or more	64%	64%	67%	66%	-2%
3 to 6 WCV	70%	71%	73%	71%	-1%
7-11 WCV	47%	48%	49%	N/A	-2%
Adolescent WCV – Annual Visit	44%	43%	43%	39%	5%
Adolsecent WCV – past 3 years	78%	77%	75%	72%	6%
Annual Dental Rate (2-21)	61%	62%	61%	60%	1%
Annual Dental Rate for 2 and 3	44%	44%	.	.	2%
Dental Varnishing – 3 or more	58%	58%	55%	52%	6%
Dental Varnishing – 4 or more	43%	43%	40%	37%	6%
BMI	13%	11%	3%	N/A	10%
ABCD	69%	70%	74%	N/A	-5%
MCHAT	55%	53%	42%	N/A	13%
School Age Screen	10%	9%	6%	N/A	4%
Adolescent Screen	12%	11%	7%	N/A	5%
Hearing	84%	85%	87%	N/A	-3%
Vision	85%	85%	85%	N/A	0%

Number of Patients or Number of Screens	Number of patients receiving services) March 2013	Number of patients receiving services) March 2013	Increase in population receiving services or screens in past year
Eligible Pts	42665	38649	4016
Pts with a visit	141477	127434	14043
Pts with a visit	76860	66546	10314
Pts with a visit	83400	59989	13411
Pts with a visit	109997	95796	14201
Eligible Pts	606781	527175	79606
Eligible Pts	104106	94859	9247
Eligible Pts	36409	33185	3224
Eligible Pts	15715	13407	2308
Eligible Pts	56700	15601	41099
Visits w/ screening	191136	199640	-8504
Visits w/ screening	44421	36963	7458
Visits w/ screening	8822	4487	4335
Visits w/ screening	10610	5865	745
Visits w/ screening	146750	139678	7072
Visits w/ screening	182323	171205	11118

Lessons Learned
What Makes QI Work?

What Moves the Needle

- Leadership support
- Pediatric Champion
- Organized pediatric team
- CHIPRA as quality healthcare
- Manageable geographic region

What Slows the Needle

- Leadership's lack of understanding
- No pediatric champion
- No pediatric team or a team that is not organized
- CHIPRA as a separate initiative
- Unmanageable geographic region

Progression of Measures

Quality Improvement Measure Category	CCNC QMAF Claims	CCNC QMAF Chart Audit	CHIPRA C – Chart Extraction Data	CHIPRA D – PEHR Reporting
Obesity Prevention	BMI V-codes	.	BMI Percentiles. Evidence of Counseling.	BMI percentiles. Evidence of Counseling. Blood pressure percentiles.
Oral Health	Dental visit (annual) & dental varnishing rates	.	Documentation of dental home. Oral Health Risk Screen and counseling	Documentation of dental home. Oral Health Risk Screen and counseling.
Developmental and Behavioral Health	Screening rates: • ABCD • MCHAT • School Age • Adolescent	.	Screening rates: • ABCD • MCHAT • School Age • Adolescent • Maternal Depression Referral and follow-up done for positive screens.	Screening rates: • ABCD • MCHAT • School Age • Adolescent • Maternal Depression Referral and follow-up done for positive screens
Early Periodic Screening Diagnosis and Treatment (EPSDT)	Well-child visits and components	.	Adolescent Immunizations.	Well-child visits and components. Adolescent Immunizations.
Asthma	• Asthma related ED visits • Beta-agonist overuse • Absence of a controller • Asthma related hospitalizations	• Asthma Action Plan • Continued care visit • Environmental Triggers • Appropriate pharmacological treatment	.	***All Asthma measures*** from QMAF Claims and Chart Audit

Questions?

Save the Date:
Upcoming Webinars in the Series

- September 12, 2:30pm to 4:00pm ET – Stakeholder Engagement
- September 25, 2:00pm to 3:30pm ET – Improving Behavioral Health Care Quality
- October 15, 2:00pm to 3:30pm ET – Health Information Technology
- Registration for September 12th webinar now open: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html

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