

## Transcript

### AHRQ Technical Assistance to Medicaid and CHIP for Health IT and HIE

March 29<sup>th</sup> Webinar

Title: Overview of Medicaid/CHIP Health IT and Quality Initiatives

My name is Stephanie, I am with RTI International and some of you may know me as a coordinator for communities of practice for this technical assistance project that is funded by the Agency for Healthcare Research and Quality. They have a number of initiatives within its portfolio and this is just one of them.

We have over 100 participants registered for today's session, so we will wait a couple more minutes as people log in, but I wanted to say a couple things before while people get settled. The broad initiative is to improve quality of health care for all Americans and we have focused our three goals: improving health care decision making, supporting patient-centered care, and improving quality and safety of medication management. Because health care quality is an obvious focus at the Agency for Healthcare Research and Quality, and there have been provisions in the recent HITECH to act to use health IT much more closely, I hope is that today's session will highlight some examples of using health IT to improve the quality.

Before we begin, I'd like to go over a few logistics for today's session. Please note that all participants were placed on mute as they joined today's Webinar. If you wish to be unmuted, choose the raise hand options on the right of your screen to notify the host. I encourage everyone to locate that right now. We hope that this WebEx technology facilitates the operations this afternoon during today's Webinar.

Additionally, if you have a question during the presentation, please send that the question to our panelists through the Chat function. Again, you will see a window expand and you will see that you have got the choice to send it to whom you want to send your question. And please choose all panelists.

Please e-mail Sara Johnson today at S A Johnson at RTI.org if you would like a copy of today's slides. And we are currently in the process of posting all the technical assistance slides to our project Web site at the web address <http://healthit.ahrq.gov/Medicaid-Schip>. You can also find at Web address slides from presentations in 2008 and 2009 that you may also find useful.

Moving on, I would like to introduce our two speakers. Diane Hasselman will be our first speaker. She is the director of quality and equality at the Center for Health Care Strategies (CHCS)—she is currently directing Reducing Disparities at the Practice Sites, an initiative designed to strengthen small under-resourced primary-care practices serving a small volume of Medicaid beneficiaries. She also manages the Center for Health Care Strategies involvement in aligning forces for quality initiatives, the Robert Wood Johnson Foundation signature effort for increasing of overall quality of health care in 15

communities across the United States. She has helped spearhead CHCS 's regional quality improvement initiative, which tested the ability of Medicaid agencies to lead the alignment of efforts across public and private payers and purchasers to improve chronic care delivery throughout the region in several regions around the U.S.

Prior to joining CHCS, she was a director at Navigant, a national consulting firm where she provided health care services to Medicare agencies.

Dr. Rod Prior is the current medical director for MaineCare at the Maine Department of Human Services. Prior to taking that position, he served as the chief information officer, medical director, and several other positions at Franklin Memorial Hospital in Farmington, Maine. We'll hear from Diana Hasselman first, then from Doctor Prior, and I will let each one of them describe how they would like to handle conversations and questions during their session, but we do hope to have a question and answer at the end, so where the participants in this call may address questions to both speakers.

On that note, we will turn the presentation over to Diane.

Great. Thank you so much, Stephanie. Can you hear me okay?

Yes.

Okay. In terms of handling questions, I will do my best to look at the Q&A, or hand raising throughout the presentation, and I can almost surely guarantee you that I may miss some questions but I will try to stop to see if there are any questions and address it, and I am certainly happy to answer any questions at the end of my presentation as well, so hopefully these three strategies will address any questions the audience might have. Does that sound like a plan?

Okay, great.

I went to first of all send a big thank-you to AHRQ and RTI to present on this Webinar; we are incredible incredibly excited about the changes coming down the road for Medicaid, for quality and particularly around HIT, so I am excited to speak this afternoon to many of you all. So I will then ask Stephanie for some help with advancing the slides, and I will be on the slide about an overview of my presentation today. First of all, I will bring in a brief introduction to CHCS and we are and what our mission is, that will focus on opportunities in Medicaid and CHIP to improve health care quality. And I will focus on for pockets of initiatives and activities that are going on. These are the four buckets that we have been most involved in and which is why I feel most comfortable speaking to those, but there are some activities it is hard to narrow down. On the next slide, the CHCS mission, the one you may be familiar with the Center for Health Care Strategies. If you are not, just very briefly, and are a nonprofit health care resources center, based right outside of Princeton, New Jersey. We were initially funded by the Robert Wood Johnson Foundation, and our whole mission is to include health care for the portion of people with chronic illnesses and also health disparity. And we do this by working one-on-one with almost every state agency so far, and we have also done a lot of work with the health plans serving the Medicaid population.

Increasingly, we are doing the work at the point of care, i.e., with Medicaid providers and practices, which is also very exciting particularly when you see that that is where quality and HIT really start to solidify from our perspective.

We bring a national perspective to you on what Medicaid programs around the country are doing around quality, and we also can serve as a connector. So if you hear information today about a project or a state that is doing something particularly innovative around quality, and you would like to hear more, just let me know and I can make sure to connect you to that source. So that is a little background on CHCS.

On the next slide, I wanted to just provide some fast facts about Medicaid, and none of these should be very surprising, but Medicaid is the largest health care purchaser in the United States in terms of covered lives, and it is growing. As you know, with the passage of the health care reform last week, an additional 15 or 20 million covered lives will be expected over the next several years. As such, Medicaid agencies have tremendous purchasing power. They have a tremendous leadership and other resources to bring to the quality improvement activities, resources like data, quality improvement strategies that you will hear about today.

So we think of Medicaid agencies really as 50-plus kind of learning laboratories, where you all are experimenting and trying to figure out what works around quality, and what doesn't. What appears to improve care, etc. And we believe that that Medicaid has the opportunity to transform our health care system, and my presentation will really focus on different ways that states are doing that.

On the next slide—I do want to throw out—Doctor Prior, I looked at his presentation and he will do a brief one on quality, for those of you who may be less familiar with this topic, but suffice it to say, simply put, health care quality is getting the right care to the right patient in the right setting at the right time every time.

And again, Doctor Prior will go into more detail on exactly what quality is in his presentation. But given that statement, I'm going to talk then about four specific pockets today about what states are doing in quality improvement. The first I will talk about is really pushing and driving quality improvement out to the point of care, where doctors and patients are meeting face-to-face. The state Medicaid agencies are getting involved in this. The second bucket I will talk about is using Medicaid resources to identify and address disparities in care. So where disparities in care exist, finding out what we can do to work together to fix them and address them and not just judge them.

The third bucket will be around strengthening care management and care coordination services, particularly for high-cost, high-need Medicaid patients. This is one place where Medicaid really has an opportunity to excel, but the commercial sector just does not know how to do this, and this is a great opportunity to improve quality and Medicaid. And the fourth bucket is going to be around collaborating with commercial payers and how Medicaid can be a catalyst in multipayer quality improvement initiatives.

The point is, while all of these four buckets of quality improvement qualities are going on now, HIT and health information technologies whether it be registries or EHRs or the data exchange that comes down the road, it will definitely help catapult the state's QI agenda so I am going to tease out common themes.

So the next slide, this won't be any surprise to you. You have been involved in this multistate collaborative for a while now in preparation for the upcoming changes with upcoming changes with ARRA and HITECH, and just to summarize, this is an unprecedented opportunity to drive EHR saturation throughout the Medicaid provider network. There will be some substantial technical assistance practices for eligible practices, and Medicaid agencies and Medicaid health plans can really help providers capitalize on the incentives programs, but there must be an understanding of the practices are the providers resource needs, so it is not enough to just hand them a check or a EHR package and say go for it; there needs to be a strategic and thoughtful way to introduce providers and the Medicaid community to this unprecedented marriage of QI and HIT.

On the next slide, transforming primary care. This is the first of the four buckets that we will talk about today. Many of you will also be very familiar with the challenge going on right now, which is an understatement in the primary care infrastructure. We know that private physicians play a critical role in the safety net. We know that they account for about 78% of visits for patients with Medicaid or uninsured patients. Private physicians also provide about 63% of primary services for minority patients. And these practices, particularly those serving the Medicaid population are really tied up under siege right now. And there is a great need to support them through quality improvement and HIT. There continues to be a dramatic decrease in medical students that are choosing primary care, and there is also the "hamster wheel" of work demands that we will often hear practices talk about.

On the next slide, we do know that systems with strong primary care systems yield lower cost and higher quality care. In response, there have been numerous medical home demonstrations throughout the states. Medicaid is testing a lot of different reimbursement and incentive strategies, and I'll touch on a couple of the main ones that we have been excited about.

The point here again is there is a tremendous opportunity through HIT to promote that infrastructure and support these medical home efforts, whether HIT is used to gather and track performance data intermission, whether registries or EHRs are used as a tool to teach the culture of quality improvement, which will be very near to a lot of primary care practices, HIT is a way to help facilitate best practices and also to manage and coordinate chronic care. So let's move on to a case study. Many of you may already know about what New York State is doing with the Department of Health but this is one of the most exciting efforts that states are doing. And this is the Department of Health but I wanted to underscore that it is a public player doing this work in New York City, and it has been called the most ambitious effort nationwide to harness electronic data for public health goals. It is the Department of Health that is doing this work, they are both an innovator in designing and rolling out this program. They are funders, trainers and deploying practice improvement or QI facilitators to work with some of the most vulnerable, under-

resourced primary care practices in New York City, and they are also policy drivers in this effort. They are trying to identify what works around strengthening the primary care infrastructure. What are the tools that you need, which should you target, when and how frequently, etc. So there is a large amount of funding in this effort coming from a variety of different funders. The Department of Health is targeting primary care practices that have a high volume of Medicaid or uninsured patients. They're hoping to subsidize the funding for this practice is to participate in this initiative, and the goal of the initiative is to improve the quality of care in medically underserved areas through HIT. So the DOH is deploying teams of coaches, multiple disciplinary teams to work with practices to implement EHRs. Practices received a license, the database, they receive 10 days of training, they receive solutions for data migration, and they receive 10 visits for training for the implementations and training around the EHR and 2 years of maintenance.

The program is also linked to patients who entered medical homes. The EHR is a critical component of becoming a medical home, and department it is also linked with performance, so there are additional dollars that are rewarding practices for undergoing this transformation and participating in this initiative.

The department provides a suite of services, which includes primary care (patient served) medical home preparation, they are hoping that the practices achieve the PCMH levels and will be able to access increase provider reimbursement from the state. They also provide smaller practices with assistance for billing around engaging patients. So it is a multidisciplinary approach. EHRs are at the heart of it but it is a much more ambitious project than just implementing EHR. So that is New York City. Let's move on down towards the center of the country.

On the next slide, we're focusing on Oklahoma. Oklahoma is another wonderful example of Medicaid and the state really spearheading a primary care medical home initiative, with HIT at the core and the heart of what they're doing. Oklahoma has the health management program, or HMP, started in 2008. And a critical component is adoption and demonstrated use of clinical measures and a registry, is a web-based patient registry called Care Measures.

It was designed by the Iowa Foundation for Medical Care, which was a contractor to the states. And it practices tracking patients with more of a variety of chronic conditions, and so tracks not only Medicaid by the other patients, so commercial, or Medicare or whoever they would like. But it captures data and it calculates the performance of several chronic conditions. So the state kind of arms these practices with the technologies but it also gives these practices a practice facilitator or a coach who is going to help these practices to use the care measures registry, to update and report data, and it also helps the practice on a regular basis to print outpatient summaries—for example, in advance of a patient visit. So the practice can identify who their diabetic patients are and their care needs. It has really made the staff, everyone from the receptionist to the medical assistants to the physician assistants, really address clinical care in a proactive, collaborative way. Now the teams are able to identify gaps in care and then assist the clinician in closing those gaps.

They are at different stages of getting practices engaged in the HMP program. Care measures are a critical part, and there are financial incentive links to each of these stages, so it is our billing is mix of quality improvement HIT, then getting some of the financial incentives almost bordering on payment reform into the mix. So in our minds, this is a great example of meaningful use of data, and using it to report clinical measures produces lists of patients who have specific chronic conditions. It just encapsulates so much around quality financial incentives and HIT. So that is the end of the first bucket around primary care. I will stop to see if there are any questions and then, Stephanie, if you need me to move more quickly, let me know.

The second bucket is around identifying and addressing the inadequacies in care. So this is an area where states are doing enough work around looking at and aggregating claims data, calculating performance at the provider or the physician level, so that again, practices can get a better sense of their performance, and the quality of chronic care that they are providing. States are providing access to data, which is a powerful tool to help stratify performance at a provider level. States are aggregating and analyzing information, which is so critical to identifying disparities, but the point here is, access to and analysis by Medicaid of clinical data from EHR will be a powerful, effective and efficient way. So once states start trying to get that data from clinical providers, they will have more tools to start identifying disparities.

In the next slide, very quickly, a case study from Detroit, Michigan, where six health plans are working together to support small high-volume Medicaid practices. They are helping to provide quality improvement in implementing registries and practices to help measure and improve patient care. These practices are all practices where the state knows that there are large Medicaid practices. They have a large proportion of racially and ethnically diverse patients, and in many cases, the practices are owned by minority physicians, which tends to be more under resourced than other practices and other physicians. So this is great example of quality in marriage to HIT.

The next slide, I will not go into this, this just says that there are lots of different tools that Medicaid has available to work to strengthen small practices, the primary care infrastructure in HIT is certainly one of them.

On the next slide, let's turn to North Carolina: always doing wonderful innovative work around quality. Again, this is a program for the state is working with improving performance in practice, which began as an initiative funded by the Robert Wood Johnson Foundation to implement EHRs and registries in practices across the country, and they are in North Carolina, and IT is partnering with Medicare to do this. They have implemented the doctor registry to understand their performance at the point of care. So again, meaningfully using this data and this information.

Let's move on to the next bucket, which is strengthening care management. There is a huge need on many levels for greater coordination of care and services from the patient to all of that many physicians, and patients with several chronic conditions may have. We know that it is not unusual to visit 16 physicians per year or more.

Some opposition primary care providers really struggle to get connections to specialists and to get specialty care for their patients. And also, from a patient to their individual provider. There is one study that shows that half of the patients left the office not understanding what they're told by their physician, and that percentage is certainly even higher if it is Medicaid focused.

In the letter to the CMS, it's the one that the Medicare directors sent to CMS for the Medicaid provider incentive program, one of the things they requested was additional care and coordination measures to be added to the list of meaningful use measures. So a very important point. On the next slide, we go to the Pacific Northwest and Washington. This is great example of where Medicaid is really advancing care management and care coordination by giving care managers access to patient-level data for care management purposes. And they have gathered all claims which is no easy feat as you may know, from physical health, behavioral health, pharmacy, hospital and ER into one user-friendly database or interface where a care manager can go in and identify at the individual client level, the risk—you know, the level of risk for this patient, services received, services not received, information that the care manager needs in order to provide effective care management and care coordination for a patient.

So you can imagine, with even greater access to clinical data and critical connections across providers to the state, how it enriched the source of information will become in the near future.

On the next slide, I wanted to throw in an exit poll of quality improvement in HIT from the health plan perspective from Southern California, and D.C. A couple of plans who are also testing PCP. Specialist E consoles. And this is helping again Medicaid primary care access for their Medicaid patients. And PCP techs can get special consults, through the E Consul platform, and this helps to really address the challenges and inefficiency and cost incurred by Medicare providers trying to access that special physician network and there is an incentive for providers to participate.

The last thing that I wanted to talk about is this alignment that we are really seeing across the country between Medicaid and other payers. So commercial payers, state employees, health care insurers, we are hoping increasingly that Medicare will come to the table, but because Medicaid represents such a large proportion of state residents, is an increasing critical player in the multipayer QI initiative springing up all across the country. And at the heart of these, are states and regions getting claims data across payers and major in performance again at the practice level, the medical group level, sometimes at the physician the ball. And Medicaid bring so much to these initiatives from its "neutrality" to Medicaid claims data and REL data to its quality improvement expertise and particularly the HIT incentive. There is, as you know, increasing excitement around EHRs and Medicare and Medicaid incentive programs.

Related to this, a lot of these regional nonprofit organizations will be intimately related to the regional extension centers. In some cases, they are one and the same. And also to the HIE. They're programs that Medicare programs need to connect with. And I just want to highlight one case study from Minnesota although we see these all over the country to

Maine, Kansas, where Medicaid is aligning public reporting and performance measurements with public payers and aggregating ensuring performance data, and this aggregate information is being publicly reported so a better quality of care across the panel that the consumer does and patients can gather more knowledge about the quality of care at the practice or the medical group level, so those are the case studies that jumped to mind when Stephanie called us about this presentation.

I don't see any questions from the Chat function right now where the Q&A function, but I notice that your voice was breaking up a little bit of hope we can manage through. And it worked out okay.

So let me take hands now, if there are any participants, you can go to the right side of the screen and press the hand icon to let us know if that they would like to ask a question.

I'll ask one question. It sounds like the Department of Health in New York City is serving in a similar role to what the RECs are doing in providing resistance and in a petition. And I was wondering if, from your perspective, what opportunities and challenges are there now in having the regional extension centers separate from Medicaid agencies and helping Medicaid providers and how the Medicaid agencies might interact with a regional extension center to achieve some of the same goals and case studies that you have highlighted in this presentation?

That is such a great question. Hopefully you can hear me better. That is a great question, and one that we are seeing. So in the New York City example, they actually will become the REC, in New York City, so in that situation there is alignment there.

What we're seeing in other parts of the country and other states is that Medicaid is very engaged with the regional extension centers across the country, I think where there can be greater coordination is when the REC really get a sense of what it will take to get into some of these Medicaid eligible practices to work with these practices. I think they may be taken aback by how challenged and under resourced these practices really are, and that it will be so much more than just implementing an EHR. There is such an opportunity to transform and strengthen the primary care infrastructure so it is our hope that RECs will turn to Medicaid in partnership and say, we know that you know your practices and the town is that you are facing, help us, or let's work together to outreach to them to assess their needs and develop an approach that is so much more than just implementing EHR.

Like, in New York City, addressing so many other needs that the practices had, and that in turn makes the EHR adoption and implementation operation so much more successful.

Thank you very much for your excellent perspective, and national perspective. Now we have the opportunity to turn to Doctor Prior's presentation. If he could give us a perspective from one corner of the country, almost literally.

You have now got the ball so you can advance the slides but your presentation. We don't have any other questions right now but I encourage participants as the Webinar goes on, send along other questions that you have and you can to those up for the last 25 minutes of the Webinar. So the floor is yours.

Hello to my fellow Medicaid medical directors. I took a peek at the attendee list and I see that there are a number of you, and the queue for much of your work that has led in part to this present opportunity.

This afternoon, I basically wanted to talk privately about quality improvement in Maine and in MaineCare. And I will take a step back about what is quality and what is quality improvement, and my apology to those of you who has spent years in the field, I suspect there are those of you that have not. And what I wanted to spend a moderate amount of time talking about was the present status of the quality of the many initiatives that are going on. Most of them are not under the tutelage of MaineCare but collaborative efforts. We will talk about our present CHIP program and then the grand opportunity that has been given to us to move the ball forward in the quality improvement arena. So this is what I will be talking about. What is quality and value in health care and how do you can prove that. And a little bit about our own primary keys management program and our application of the bright futures project for the American Academy of Pediatrics. And then talk about how the CHIP grant represents the net project because I and very much they keep that in that context.

So what is quality, and why are we spending so much time on the issue? I think a very good place to start is with the statement that comes from the Institute of Medicine in a book published 11 years ago called Crossing With Quality Chasm, of course many of you know about, but I wanted to read to you believe the first paragraph of this book. The U.S. health care delivery system does not provide consistent high quality medical care to all people. Americans should be able to count on receiving the care it needs based on scientific knowledge, that there is strong evidence that this is frequently not the case. It frequently fails to routinely deliver its potential benefits. Indeed the health care that we now have and the health care we now have and I wanted to point out a couple of things.

First of all, the expectation that health care should be based on the past scientific knowledge. Second of all, the patient safety, oftentimes the health care can harm as well as hurt those of you who are in my profession and know that one of the basic tenets that comes from the Hippocratic Oath which is, first do no harm. And often we do harm here.

The other thing to say which I think is most widely known is that we have the most expensive health care system in the world. Twice as much as with the next country in line stands at over half of what the industrialized countries spend. And yet, in one broad measure of health, we rank 37<sup>th</sup> in the world.

You also know, and Doctor Jack Wittenberg has told us that there is great variation in both the demonstration of quality and health care from place to place and in the demonstrated cost of health care. So we are not getting the best outcome for the dollars that we spend. But in one of the comments that his people made, and this was comparing the finest academic medical centers across the country and finding even in those abroad variations, and the question, how can the best health care in the world cost twice as much as the best health care in the world? So we have a problem.

Also, I wanted to point out, we also realized that we not only have a quality program, we have an access program and a cost problem. And that's very much represents the balance. And we are going to have to manage not just equality but all parts of the balance. Because if we try to manage one part of this three-legged stool, we may very well find that we could improve on one or two, but at the expense of the other or the other two in the way that we find unacceptable. So in terms of moving the quality agenda forward, we must keep our balance between cost that we're willing to pay and can afford, access hopefully for all of the people, and quality.

I also wanted to talk a little bit about the movement between quality assurance to quality improvement. And if you look at the left-hand side of this, the tenets of quality assurance. And I would point out that the notion of quality and health care is really not a new notion. Throughout the century there have been many moves to improve the quality of health care going with back to the beginning of the 20th century and a broad review of the American medical education and the movement of medical education into a university and science-based organizations like the American College of Physicians and the American College of Surgeons for the joint accreditation of hospitals. And the development of licensure of standards and so forth. But during all that time, the notion was assuring the quality was an acceptable standard, not of trying to improve quality. There was a reliance on inspection, a focus on individuals—that is, we doctors that are not held in divisional irresponsible, and we found a problem and we punished it. Also, quality is a separate function. We put quality of on the department and it is a function. It is not a system's function or function of the whole, but of the individual pieces. And we move from that to a notion of quality improvement, where we are trying to constantly improve our performance. We need to monitor overtime. And we are trying to get a systems view of health care and teams and realize that quality is oftentimes built in and not added in after the fact. And it is really all of our jobs, the job of the whole organization working together.

Which brings us to Professor W. Edwards Deming who was a statistician and actually got his start in American industry during World War II, but he learned and wrote extensively in part using statistical methods in terms of measuring quality and using data to improve quality. And his definition of quality is a never-ending cycle of continuous improvement. So instead of that the static, quality now becomes a dynamic. And it is primarily used in Japan and in the Toyota way, and despite Toyota's bad press and the last few months, it is still one of the highest quality cars in the world.

Another statement, sometimes run equivalent to Deming but apt in this instance, is that quality measures cannot be managed or improved. And I think that really comes to us that in order know what quality is, in order to measure how good the quality is and in order to find a method to improve the quality, we need data.

So I think that this circle is one of the easiest ways to think about quality improvement. Those of you who have been in it as long as I have, you remember the days when TQM and CQI were hot things, analysts say, I found them confusing and it took me a long time to even understand what they were trying to do. Islamic it has been boiled down to this simple circle, this so-called Plaza, too, study, Act circle. Which really talks about the

essential cycle of measuring and analyzing on the one hand, and making and instituting changes, measuring the results assessing the results, and starting all over again? It is also in terms of trying to institute this cycle, you can start anywhere. If you have an emergency, and if you have got to do your best to make a change, go ahead and make the change, but don't make the change without studying it to make sure it is brought about the needed changes, and continue to study it because there are undoubtedly changes that can be made.

I also wanted to introduce the concept of value in health care. Value is generally defined as quality / cost. If you go to the Web sites that I cited here, you'll find that in fact, the CMS and federal government, as well as most of the forward thinking private purchasers of health care have rarely focused on value as a way of bringing cost and quality together, so that their interest is improving the value in health care, and purchasing value-based health care.

So what does health information technology have to do with this? These are the four cornerstones of value-based health care is defined by CMS, and I think they are really representative of a good way of thinking about health information technology.

First of all, in order to assess value we need comparative information on the quality of health care. Those are two of the cornerstones that I put together. They are also suggesting that the purchasers of health care should be paying for high quality and efficiency, and other words, paying for value-based health care. And I think as many of you know, our infrastructure is largely based on service care, which is based on volume: the more you do, the better than you get paid. And sometimes those incentives may not lead to the best health care, and part of the great debate that we're having right now is how to reform the payments system to have better value-based health care.

Then finally, health information technology is an absolute necessity. It is not good in itself, that as a tool to make information available and organize it allows information to be reused or be recorded once and reused for multiple purposes, or broad communication and information sharing, for patient, analysis, and [indiscernible].

So quality improvement in Maine. What have we been doing?

Well, we started in the late nineties with an experiment in traditional Medicaid managed care. And we brought in managed care companies to the state. We put out an RFP, and with only received a single response. And because we only received this in response we started on a small business and a voluntary basis.

It didn't go very well. Not very many of our members were interested in signing on. They did not see the benefit. Most of the providers were, if anything, lukewarm. After less than a year, the company that was provided by managed care here decided they wanted to stop the experiment.

After that, the Primary Care Management System had been announced by CMS and we have decided to apply for and received permission to transform part, and now virtually all of our benefit care benefits also our PCCM program has almost eliminated the physician

access problem and their contract with the PCP has a fairly low impact contract for them. We do require 24/7 access by phone and compliance with referral mentioned systems and with our PTL. We do pay them per member per month and we do have a primary physician incentive program ended place. We distributed about \$2.7 million in incentive payments based on will TIF performance on a set of children's and adult measures on cost, quality and access.

In about 2000, we started our Bright Futures program. I am sure that many of you are quite familiar with the Bright Futures program, a national program of prevention and health promotion dedicated to the idea that every child deserves to be healthy and optimal health involves a trusting relationship between the health professional, child, and the community as partners. This first developed with support from the Health Resources and Services Administration and Academy of Pediatrics, and has been taken over by further development by the AAP on the future development of the AAP Web site. We started instituting the Bright Futures program in 2000. The first thing we did was to develop 20 well child visit forms that helped pediatricians and other pediatric providers guide growth. We use our system to find children and adolescents that seem to be due for well to help care, and are reminders to parents to have that information.

We also ask that physicians fill out and submit the Bright Futures forms after the well child checks. We developed a Web portal and hoped that the providers will use that but also allow submission of paper-based forms. We found that the Web portal is almost unused and the universal reason, the physicians say for it is that it is double work. And some of our physicians use our Bright Futures forms as their well child forms and you may find them scattered through medical records of pediatrics providers, but even if they use the paper-based forms, if they were going to submit it via the Web portal, it would have to go and enter the data. So in general we found that there we were not able to force compliance with the use of the Web portal and we have come to accept that level and the overall compliance is around 50%. That is, of all of the kids seen, we get about 50% on these forms.

We do use the forms, and we have to vault the collaboration between MaineCare, which is our Medicare agency, and our sister agency now called the CDC which used to be Public Health, with support of our public health nurses. All of our public forms whether they come in on paper or the Web are scanned by the nurses for abnormalities. And then the nurses follow up as needed. We have set up a database of only those at the abnormal, and we have no database of the entire Bright Futures data, and after the forms are scanned, they are eventually destroyed. So we have had some success. We have particularly well integrated with Maine CDC who does provide clinical follow-up for the kids who need a follow-up. We were able to use our regionally based public health nurse system to reach out those families or kids who show up as abnormal on our Bright Futures visits. And we are also better able to integrate but that state health lab which does things such as lead testing.

There are some drawbacks. It also requires a huge amount of clerical work and a huge amount of work for providers who sent us are forms. We have very little analytical capacity to use the data, and we don't really monitor or manage the cost, as is true for all

of the programs. We have reporting requirements but we're not able to use the data very well for our reporting requirements. And we really have not been able to use the data for quality improvement, this has been a largely static program.

I wanted to talk very quickly about the CHIPRA indicators and I see that both Jeff Schipp and Mary McIntire are on the phone. And I think these indicators are extremely important to all of us. Because for the first time, they really represent a good comprehensive set of indicators of quality and value of children's health. They cover half growth and development and here they are quickly. They cover the access to care, acute care, chronic care, the care of existing illnesses, patient experience and care, prevention and safety. And I won't say any more about them. They are obviously here on the slides and if you Google CHIPRA, you will find them.

So who are the users of the CHIPRA indicators? I think the reality is, although there were developed in the public arena, I think we will be finding that they were extremely broadly applicable to error on Medicaid programs, to other purchasers of health care, to the providers of children's health care, and to the public. And they will be valuable for the reasons that we talked about of quality improvement, and for the pillars of value-based health care. Among other things, when the transparency of comparative cost and quality information.

And we need ways to feedback that information to providers as well as the public itself. So the question really becomes, how do you collect the data for the CHIPRA indicators? These are the methods that I know of to collect data. We can collect them by method of attestation, and that is, we can ask providers, did you meet the indicators, and if you in fact look at the HIT standards, we will be using the attestation for the meaningful use standards, but in long run, we really need better mechanisms.

And most of us already use claims, and as you probably know, those are largely based on HEDIS claims data, and the claims data are a very good source of information about quality and value and health care, but at the same time they have many limitations.

We could use tabulated data, which is typically captured by practices and they will report their numerator and denominator and that is a better method than attestation, but it is often times a very laborious method for the practices, particularly if they don't have an electronic health record that can do reporting, or a patient registry. But the best way is to really get a piece of specific data—to get that data and the degree that data with other data sources that have more comprehensive data levels and equality of access that that patient has.

I wanted to talk very briefly about a couple of our partners. There are many organizations that are involved in quality improvement activities, and by and large, we are trying to build on the work that they are doing and have done. We'll talk with the Maine Health Management coalition which is kind of the Maine leapfrog group, for those of you that have the national organization. The collaborative has been involved in the public reporting of information and I am providing the Web site. It puts money into incentives for providers. One public purchaser actually uses the results and hospital providers and

Maine Health Management Coalition Web site as noted here, and it will waive copays and deductibles to members based on going to doctors and institutions that score really well on the measures of quality. Maine Care was actually a latecomer but is now an active member, and we do use as a piece of our quality measurement and quality incentive programs, we use that Maine Health Management Coalition majors to some extent.

Quality Council is an organization that is provider based; it's focused not on public reporting or incentive piece but on working with provider organizations and learning to use quality improvement. It runs an annual improvement conference and in the last 4 years has been extremely active in the Robert Wood Johnson Foundation in aligning forces for quality grants that particularly use the learning collaborative method to do most of its work. They also have a multipayer medical home pilot which is now up and running that includes Maine Care and its four largest payers all in one in our PCCM program and collectively around 5% of the primary care practice.

We are paying an additional 350 per member per month as an extent to those medical home private practices, and we are involved in a pretty rigorous evaluation by the public schools of the University of Southern Maine. In part, because all of the payers, including our own state legislature, very much want information about the quality and value that comes out of this pilot.

The Quality Counts organization is working once again with a learning collaborative with these medical home practices to improve their quality and achieve the tenets of that practice in the medical home.

Most hospitals have a well-developed infrastructure of HIT; 25% of physicians have EHR, more have patient registries, and more are involved in e-prescribing, and almost none of the physician practices are connected to Health InfoNet which is now our private statewide health information exchange. It also did data submission to our main server for disease surveillance, and we are now beginning to ramp up to a real statewide implementation, beginning to work toward getting into many of the electronic health records.

Also we have a brand new MITA system which we are about to take delivery of, which includes not only a claims system but a data warehouse, decision support, a care management platform, a virtual records system and a provider portal. So it is all that stuff that we wanted to use and build on with our CHIPRA grant. We want to collect and report on the indicators we want to build on the system to manage Bright Futures, and work with Health InfoNet to develop reporting to report those quality indicators. We suspect that is likely to shape pediatric electronic medical record development. We will work with Maine health management coalitions to provide standardized data reporting not just for MaineCare, but other payers. And to develop regular standardized feedback mechanisms to practices which, as Diane indicated earlier are the most likely people to be able to be approved with quality and value of health care received. We will be collaborating with many people to do this. This isn't really a MaineCare project only by

stretch, it will be working across the department with that Muskie school and Health InfoNet and others to achieve this but we're just getting going right now.

With that, I am stopping. I hope we have time for questions.

Thank you so much. I will turn it over to our participants. If there are participants with a question, please put your hand up.

What are the next steps in responding to the public comments submitted to AHRQ? And perhaps, Sarah, we could unmute David, who posed that question to the group for a further clarification. But I am wondering if that was meant to be a comment about the CHIPRA measures themselves?

This is Carol in Virginia, and the question is in regard to the public comments that were submitted to park for the proposed CHIPRA majors.

I am not sure if we have anyone from AHRQ on the line, but if you are there, if you could please raise your hand. We could take that question and bring it back to the group. We could the mail it along with a slide.

Okay, thank you.

And I'm assuming you mean, what will AHRQ do with those public comments?

Yes. Will they be posted anywhere or will they be revisiting the measures? We're just curious what is next.

In the meantime, we also had a hand raised from Jerry Green.

This is Jim Bush.

I enjoyed your talk, and we were looking at integrating the Bright Futures into our electronic health records. Are you familiar yet or is the AAP planning on making an electronic version that will be interoperable with CCHIT technology is so we don't get into the static problems that we were reporting about?

Hello Jim. I don't know the answer to that because if they would, maybe we don't have to. And also, does the AAP charge to a licensing fee for using their forms?

I don't know but I do know that built in to our CHIPRA grant is a fairly modest amount of money to buy the work book sets from Bright Futures.

Great, thank you.

I see another question coming across for Dr. Prior. It says that PCCM had almost eliminated the physician access problem. Can you explain more about this, more use of mid-level providers perhaps?

There are a lot of answers to that question. I would say that the approximate answer to that question is, MaineCare has traditionally not paid very well and in fact, until a year ago, we paid about 53% of the Medicare rate. And we have recently increased 273% of the Medicare rate. But because of that 350 per member per month, and the incentive payments, the total payments to primary care physicians are almost at Medicare levels. That has made a big difference. But there are other reasons as well. Maine is very rural and because of that, parts of the state are eligible to that that really qualified health centers and rural health centers which, as you probably know, receive advantage payment by Medicare and Medicaid. And that has helped with the primary care access problem and in addition, many hospitals started primary care practices and used the provider-based reimbursement system, which again, is available to be able to receive diminished reimbursement.

And about 40% of their access comes from hospital-based physicians out of a third front FQHC and only 20% from private physicians. So all of those are reasons why.

Alice, if you have a follow-up question for that, I just want everyone to know that we have been muted everyday, so feel free to speak up now if you have a question. We have unmuted everybody, so feel free to speak up now if you have a question.

This is Dr. Carson in Georgia, and I was calling to find out whether or not Maine has seen actual improvements in patient outcomes as a result of your transition to quality improvement versus quality assurance?

That is a really good question. I am chagrined to say that my lecture about quality assurance moving to quality improvement says more about the size of quality improvement than it does about our work within MaineCare. We have had some modest quality improvement efforts. But one thing that we really lack is the ability to measure. Abbott said that one of the things that we are really committed to rigorous ongoing mission so that we could answer this question.

One more question in follow up. Are you utilizing any performance measures now and tracking them over time?

We are using this incentive program in place, and we are now beginning to track over time. And we had a claims system meltdown in 2005 within MaineCare, and it really, for about 2 years, we had almost no data to manage, and that really made a difference in our abilities to track overtime, and we now have the ability to track more in the CHIPRA grants.

The promotion of EHRs, will we do away with Bright Futures and paper forms? I suspect the answer to that question is not for awhile, and as I said, only about 25% of our providers have electronic medical records. In addition, I suspect without knowing at this time that it will require considerable work to be able to collect Bright Futures data within those electronic medical record systems as well as to build electronic interfaces. And I think that is one of the thrusts of the CHIPRA grant program is to get some dynamic experience of that. And as far as overlap with HEDIS measures, I haven't actually done

the crosswalk. To the extent that the majors are essentially the same, that could be problematic. I would suspect, we don't have to use heat as measures, we have no traditional in a ... but for children's health, I expect to be major Rushmore on the CHIPRA majors and find that there are duplicates we made.

Any other questions from participants?

I have a question for both Diane and Dr. Prior. Do you know of Medicaid agencies or are you yourself (in Dr. Prior's case) involved in collecting data from providers or electronic health records systems?

That is absolutely our intent to do that where possible. And we have a close relationship with their statewide health information exchange and we are already collecting some data into the state from the information exchange, which is where we are collecting laboratory data for disease surveillance purposes.

So to some extent, we have begun to build some of those bridges already. And we expect to use this grant to further that by these quality indicators.

This is Diane. I guess I would say that we're seeing that around the small multipayer regional quality initiatives across the country. Like Minnesota and Cleveland, there are pockets across the country where this is happening but Medicaid is working with commercial sector providers that have EHRs and because they have EHRs, are reduced across all the payers. The catch is not only of commercials but Medicaid as well.

So there are kind of pockets, but you raise a good question. That is probably more driven by the commercial sector, I would say, and I would say that Medicare providers would be underrepresented in the sense so far, since so few have EHRs now and are able to submit clinical data. So I don't believe that is helpful. I think that is still in very early phases.

One other comment that I would make is, there are opportunities beyond practices having will electronic medical records. In particular, some practices have elected to put into place patient registries or illness registries, and those also represent good opportunities to look at the possibility of trying to capture this kind of data. For example, in our own state of Maine, MaineCare is the largest integrated delivery system in the state and has implemented a clinical disease registry system which is broadly supports in hundreds of practices. So I would strongly suspect that we would be approaching them about the possibility of extending its purposes to begin to include some of this data that is implied by the CHIPRA indicator.

I think you raise an interesting point. And that is, a lot of practices and Medicaid programs have registries they are using. Does that have to morph into an EHR? Maybe registries are an appropriate tool and a stepping stone to get otherwise under-resourced practices towards meaningful use. I think that will be an interesting discussion that the states will be having and I know that CHCS is interested in hearing what they have to say.

You have to understand the obverse. Just because a practice has an HER, that does not mean that they aren't necessarily in a position to be able to report structured data out through an exchange, and a lot of the present generation systems have been built to support clinical practices and are document management systems rather than data management systems. And they really vary greatly in the ability to do that. So I suspect that building these interfaces will be very hard work. Among other things, I wanted to develop data standards because that is what the vendor will want to respond to. Because once they know what the data standards are, that they can respond and build systems to meet those standards. But until the standards are in place, they can't, which is one of the reasons why the CHIPRA indicators are important.

I would like to thank all of our presenters for their presentations today and yielding good questions from the audience and for all of our participants for their interest in the subjects. And I would like to encourage people to subscribe to this project if you are not already, and we will use this list serve to advertise future events like this and also advertise some of these questions and take your questions or at the next several months as you are having them and use this to pose questions and answers that are of interest to the Medicaid and CHIP community. I would like to implore you also to fill out the evaluation for this Webinar. Immediately following this, an evaluation form will appear on your screen, and this information is very important to us as we plan future sessions. We are interested in your reactions to the topic, and if you don't have time to complete this, please feel free to e-mail Sarah and she will follow up with you by e-mail. And again, thank you for participating. We have another generic e-mail address for all of your comments and recommendations for this project. And of course, you can look at for the rest of technical assistance materials and future sessions on our Web site, and on that Web site you'll find not only past presentations but also a repository of literature where you can search for more information and perhaps additional articles and such that touch on the relationship between quality and health IT. Thank you very much for participating in for your attention today. We look forward to seeing you at future events.

>>> [event concluded]