Technical Assistance for Health Information Technology and Health Information Exchange in Medicaid and CHIP

Welcome to the AHRQ Medicaid and CHIP TA Webinar

Health IT as a Means, not an End: How Health IT Supports Broad Quality Improvement for Medicaid and CHIP Beneficiaries

Monday, March 29, 2010, 2:30 – 4:00 p.m. Eastern

Presented by:

Dianne Hasselman, MSPH, Director of Quality and Equality, Center for Health Care Strategies
Roderick E. Prior, MD, MPH, Medical Director, MaineCare

Moderated by:

Stephanie Kissam, MPH, Health Services Research Associate, RTI International

*** Please note all participants were placed on mute as they joined the session.**

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Overview

- **Welcome** – Stephanie Kissam, MPH, Health Services Research Associate, RTI International
- **Before we begin** – Stephanie Kissam
- **Introduction** – Stephanie Kissam
- ***Health IT as a Means, not an End***
  - Presented by:
    - **Dianne Hasselman**, MSPH, Director of Quality and Equality, Center for Health Care Strategies
    - **Rodney E. Prior**, MD, MPH, Medical Director, MaineCare
- **Questions and Answers** – Stephanie Kissam
- **Closing Remarks** – Stephanie Kissam

Before We Begin

- Please note all participants were placed on mute as they joined the Webinar.
- If you wish to be unmuted, choose the “raise hand” option to notify the host.
- If you have a question during the presentation, please send your question to ***all panelists*** through the chat. At the end of the presentations, there will be a question and answer period.
- Please e-mail Sarah Johnson at sajohnson@rti.org if you would like a copy of today’s presentation slides.
- We are currently in the process of posting all of the TA Webinar presentation slides to the project Web site: http://healthit.ahrq.gov/Medicaid-SCHIP

Technical Assistance for Health Information Technology and Health Information Exchange in Medicaid and CHIP

Health IT as a Means, not an End: How Health IT Supports Broad Quality Improvement for Medicaid and CHIP Beneficiaries

Presented by:

Dianne Hasselman, Director, Quality and Equality
Center for Health Care Strategies, Inc.

Overview

- An introduction to CHCS
- Opportunities within Medicaid/CHIP to improve health care quality
  - Transforming primary care
  - Identifying and addressing disparities
  - Strengthening care management
  - Collaborating with other payers

CHCS Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

CHCS Priorities

- Improve quality and reduce racial and ethnic disparities
- Integrate care for people with complex and special needs
- Build Medicaid leadership and capacity

Reach

- 47 States
- 160+ health plans

Medicaid's Fast Facts

60 million	People in the U.S. who receive Medicaid benefits.
$380 billion	Total Medicaid spending in FY 2009.
15 - 20 million	Additional Medicaid/CHIP beneficiaries expected by 2019.
41%	Births in the U.S. covered by Medicaid.
28%	Children in the U.S. covered by Medicaid.
50%	Medicaid beneficiaries under 65 who are from diverse racial/ethnic groups.
25%	Medicaid beneficiaries accounting for nearly 70% of total Medicaid spending.
71%	Medicaid beneficiaries who are enrolled in managed care.
22	Estimated number of States with plans reporting HEDIS performance measures.
28	States using pay-for-performance incentives with health plans/providers.

Opportunities to Improve Quality

- States are leveraging their purchasing power to modernize Medicaid by:
  - Driving quality improvement at the point of care;
  - Using resources to identify and address disparities in care;
  - Strengthening care management services, particularly for high-cost, high-need patients; and
  - Collaborating with commercial payers and catalyzing multi-payer quality improvement (QI) initiatives.
- **Health information technologies—e.g., registries, EHRs, and electronic data exchange can help drive State's QI agenda.**

EHRs and Meaningful Use

- ARRA = Unprecedented opportunity to drive EHR saturation among Medicaid providers
- Substantial financial and technical assistance incentives for eligible practices
- Medicaid and Medicaid health plans can help providers capitalize on incentive payments
- Must understand practice's resource needs (i.e., "Handing them $64k or an EHR package is not enough…")

Transforming Primary Care

- Private physicians are a critical part of the safety net:[1]
  - Accounting for 78% of primary care visits for patients with either Medicaid or no insurance; and
  - Providing 63% of primary care visits for minority patients.
- Must address the ongoing “plight” of primary care:
  - Continuing and dramatic decrease in medical students choosing internal medicine; and
  - The “hamster wheel” of work demands.

[1] Forrest C ,Whelan, E. Primary care safety-net delivery system in the United States – A comparison of community health centers, hospital outpatient departments and physicians’ offices. JAMA 2000;284(16):2077-2083.

Transforming Primary Care

- Systems with strong primary care yield lower costs and higher quality.[2]
- Numerous medical home demos throughout States
  - Medicaid is testing different reimbursement/incentive strategies
- Adoption and use of HIT is critical tool for success of these efforts
  - To gather and track performance information
  - To teach culture of quality improvement
  - To facilitate best practices
  - To better manage and coordinate chronic care

[2] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.

Case Study: New York City

- **"…The most ambitious effort nationwide to harness electronic data for public health goals…"**
- Department of Health as innovator, funder, trainer, policy driver
  - $30M from city, $30M from State/Federal government
  - Targeting practices with 30% Medicaid or uninsured
  - Subsidized funding, sliding scale available for low-resource practices
  - Practices receive 10 visits for implementation/training and 2 years of maintenance support
  - Linking EMR to achievement of patient-centered medical home certification and new P4P program
  - Linking in patients for scheduling, checking labs, monitoring progress
- 100 practices and 800 providers are now "live"
  - 1 in 10 PCPs currently using system (10,000 citywide)

Case Study: Oklahoma

- Health Management Program initiated in 2008
- **Adoption and demonstrated use of clinical measures in Care Measures registry is cornerstone of initiative**
  - Stage 1: Practice facilitation engagement ($500)
  - Stage 2: Pay for reporting via Care Measures registry (quarterly, for year 1 only)
    - Clinical performance measures: diabetes, CHF, CAD, asthma, others
    - Payment related to number of members tracked in registry
  - Stage 3: Pay for improvement (annual)
    - 40% achievement is minimum requirement
    - 10% improvement in core measures or maintenance of 80% or more to achieve award

Identifying and Addressing Care Inequities

- Analyzing Medicaid claims and quality data to identify pockets of disparities in chronic care in provider network
- Mobilizing resources and supports to improve the care these practices provide
- Aggregation and analysis of electronic information is critical to identify disparities
- **Access to and analysis of Medicaid clinical data from EHRs will be powerful, effective, and efficient way to identify inequities**

Case Study: Detroit, MI

- Six health plans are aligning efforts to:
  - Support six small, high-volume Medicaid practices;
  - Assess practices needs, challenges, and priorities, including HIT;
  - Designate QI coach and provide financial support to practices interested in becoming patient centered medical homes; and
  - **Help practices select and implement a registry to measure and improve patient care.**
    - Coaches help populate registry, interpret results, and develop process for ongoing use

Tools to Support Practices

Leadership and Change Management	Coaching and mentoring to depart new skills
Social Network	Facilitating new social linkages
Chronic Care Education	Implementing practice-based chronic care tools
Enhanced Payment	Providing up-front enhanced payment
Health Information Technology	**Implementing e-Rx, registries, EHRs**
Data	Providing aggregate and member-level health plan data
Nurse Care Manager	Deploying practice-based care manager
Practice Facilitator	Deploying practice-based quality improvement facilitator

Case Study: North Carolina

- Cumberland County (one of the 14 CCNC networks) is partnering with *Improving Performance in Practice (IPIP)* to adopt, implement and use registries in small, low-resource practices
- *IPIP* is:
  - Conducting assessments of each practice;
  - **Implementing the *Reach My Doctor (RMD)* registry tool and using data to better understand and improve care delivery; and**
  - **Providing support to practices to improve clinical measures.**
- CCNS network is:
  - Recruiting practices;
  - Providing financial incentives to participating practices; and
  - Designating a case manager to provide additional supports to each practice.

Strengthening Care Management

- **Integrated data systems are critical for overcoming "silos" around care.**
- Patients with several chronic conditions may visit up to 16 physicians a year.[3]
- In one study, the referring physicians received feedback from specialists about half the time.[4]
- In one study, 50% of patients left the office visit not understanding what they were told by the physician.[5]

[3] Pham HH, Schrag D, O'Malley AS, Wu B, Bach PB. Care patters in Medicare and their implications for pay for performance. N Engl J Med 2007;356:1130-9.

[4] Forrest CB, Glade GB, Baker AE, Bocian A, von Schrader S, Starfield B. Coordination of specialty referrals and physician satisfaction with referral care. Arch Pediatri Adolesc Med 2000;154:499-506.

[5] Roter DL, Hall JA. Studies of doctor-patient interaction. Annu Rev Public Health 1989;10:163-80.

Case Study: Washington

- Medicaid provides care managers with access to real-time, integrated, patient-level data for care management purposes:
  - Physical health claims;
  - Behavioral health claims;
  - Pharmacy data; and
  - Hospital admissions and ER information.
- **EHRs will facilitate an even greater opportunity to integrate and share data.**

Case Study: Medi-Cal Plans

- Testing PCP-to-specialist e-consults
  - PCPs receive non-urgent consults from specialists through an e-consult platform;
  - Secured Web-based portal;
  - Access to member's claims history, lab data, diagnostic tests, etc.;
  - Helps address the challenges, inefficiencies, and costs incurred in accessing specialty physician network; and
  - PCP and specialists receive payment for e-consults.

Aligning Quality Initiatives with Commercial Payers

- Representing 11 to 30% of State residents, Medicaid is critical player in multi-payer QI initiatives.
- States/regions are aggregating claims data and measuring performance across all payers at the practice level.
- Medicaid brings “neutrality,” claims and race/ethnicity/language data, QI expertise, and HIT incentives.

Case Study: Minnesota

- Medicaid is aligning performance measurement and public reporting efforts with commercial payers to:
  - Aggregate and share performance data at the provider level
    - Started with claims data, but as providers adopt EHRs, the region can use clinical data directly submitted by providers
  - Publicly report data at the medical group level.
  - Stratify outcomes by payer and use information to identify and address inequities in care.

Visit CHCS.org to …

- **Download** practical resources to help improve the quality and efficiency of Medicaid services.
- **Subscribe** to CHCS eMail Updates to learn about new programs and resources.
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost members.

http://www.chcs.org

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Quality Improvement and HIT In MaineCare

Presented by:

Roderick E. Prior, MD, Medical Director for MaineCare

MaineCare Division of HealthCare Management

Funded by the Agency for Healthcare Research and Quality

Outline

- What are quality (and value) in health care?
- How do you improve quality?
- Brief history of PCCM, EPST, and Bright Futures in MaineCare
- What does HIT have to do with this?
- The status of HIT and HIE in Maine
- How does our CHIPRA grant represent the next step?

What is quality, and why are we spending so much time on the issue?

The Quality Chasm

"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 care that meets their needs and is based on the best scientific knowledge—yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm." (Institute of Medicine, *Crossing the Quality Chasm*, 1999)

Cost and Quality

- In the US, we spend 17% of our GDP on health care, close to twice what the next country spends.
- In one overall measure of health, we rank 37th in the world.
- We know that cost and quality vary greatly across the US.
- We're not getting the best outcomes for the dollars we spend.

The Cost-Quality-Access Balance

- Access to the best quality health care for all Americans at a cost we can afford and are willing to pay.

Movement from Quality Assurance to Quality Improvement

Quality Assurance	Quality Improvement
Conforms to standards (education, structure, process)	Improved performance
Relies on inspection	Monitor over time
Focus on individuals and items	Orient to teams and systems
Quality is a separate function	Quality is integrated into the organization
Department function	Interdisciplinary function

Thanks to Loyola University Medical Center

What Is Quality?

"Quality is a never-ending cycle of continuous improvement."

W. Edwards Deming,

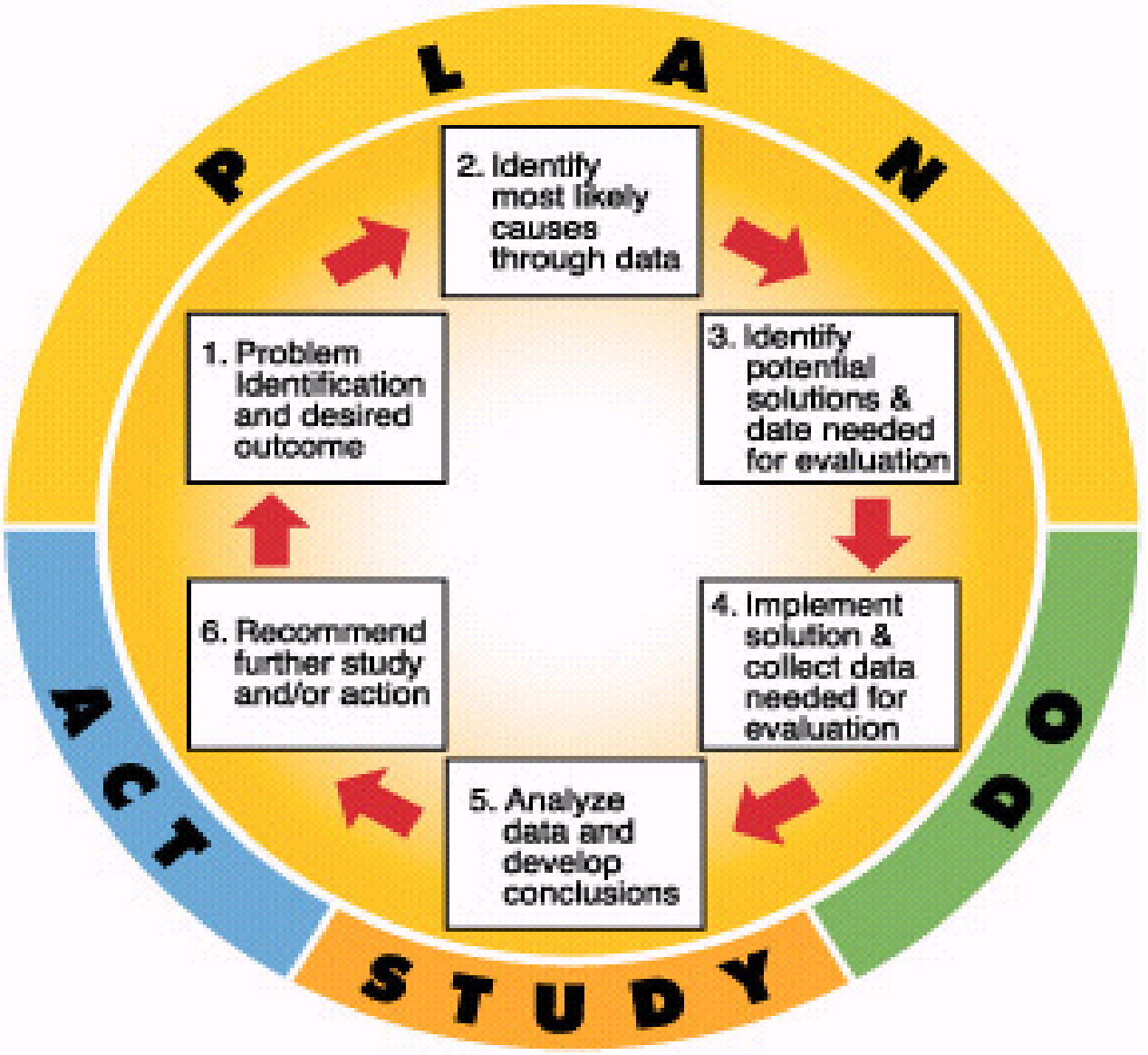
Statistician, Teacher, Author, and Consultant

Measurement in Quality

"What cannot be measured cannot be managed (or improved)."

(Sometimes wrongly attributed to Deming)

So, How Do You Improve Quality?



Value in Health Care

- Value = quality / cost

- http://www.hhs.gov/valuedriven/index.html

What Does HIT Have To Do With Value-Based Health Care?

- Four cornerstones of value-based health care
  - Comparative public information on cost and quality
  - Incentives to providers for high quality and efficiency
  - Health information technology to improve
    - Information availability and organization
    - Information reuse—record once, reuse for multiple uses
    - Communications and information sharing
    - Measurement
    - Analysis
    - Feedback to stakeholders

Quality Improvement In MaineCare

Primary Care Case Management in MaineCare

- In operation since 1998
- Started after a failed experiment in traditional Medicaid managed care
- Statewide
- Virtually all full-benefit MaineCare members
- 80–90% of all Maine PCPs enrolled
- Has almost eliminated physician access problem

Bright Futures Program

- Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship among the health professional, the child, the family, and the community as partners in health practice.
- Developed by HRSA, AAP, and others
- Part of MaineCare PCCM program since 2000

MaineCare Bright Futures

- Developed 20 well-child visit forms to guide growth and development physician visits.
- Mail visit-due reminders to parents (based on claims).
- Ask that physicians fill out and submit Bright Futures forms after well-child checks.
- Developed Web portal, but also allow submission of paper forms. Almost no use of Web portal.
- Some physicians use Bright Futures forms as their well-child visit forms.
- Overall compliance is 50%.

Bright Futures Follow-up

- Collaboration between MaineCare and Maine CDC public health nurses
- Paper or Web-based forms scanned by nurses for abnormalities
- Nurses follow up as needed
- Abnormals-only database maintained
- Forms with no abnormalities destroyed

Bright Futures Successes

- Collaboration with Maine CDC
  - Better clinical follow-up
  - Use of regionally based public health nurses
  - Better integration with public health lab

Bright Futures Limitations

- Support requires much clerical work
- Claims and program data not integrated
- Little analytic capacity
- Don’t monitor and manage costs of program
- CMS 416 reporting from claims
- No use of data for quality improvement
- Largely static program

CHIPRA Indicators

- Developed by AHRQ in collaboration with Medicaid Medical Directors' Learning Network and others
- First comprehensive set of quality indicators of children's health
- Covers growth and development and care of common acute and chronic conditions
- Physical and behavioral health

Access to Care	Access to primary care practitioners, by age and total.
Acute Care	Pharyngitis—appropriate testing
Acute Care	Otitis Media—systemic antimicrobials—avoidance of inappropriate use
Care of Existing Disease	Annual number of asthma patients (>1 year-old) with >1 asthma-related ER visit
Care of Existing Disease	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (continuation and maintenance phase)
Care of Existing Disease	Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)
Care of Existing Disease	Follow up after hospitalization for mental illness
Overall Cost and Quality	ER utilization—Average number of emergency room visits per member per reporting period
Overall Cost and Quality	Percent of live births weighing < 2,500 grams
Overall Cost and Quality	Cesarean Rate for Low-risk First Birth Women
Patient Experience	HEDIS CAHPS Survey of Patient Experience
Patient Experience	Use of Clinician & Group primary care CAHPS survey for practitioners participating in Medicaid and CHIP
Prevention	Immunizations for 2-year-olds
Prevention	Frequency of ongoing prenatal care
Prevention	BMI 2—18 years old
Prevention	Well-child visits—1) the first 15 months of life; 2) the third, fourth, fifth and sixth years of life; 3) Adolescent Well Care Visits
Prevention	Total eligibles receiving preventive dental services
Prevention	Adolescent immunization
Prevention	Timeliness of prenatal care
Prevention	Rates of screening using standardized screening tools for potential delays in social and emotional development (ABCD)
Prevention	Annual dental visit
Prevention	Child and adolescent Major Depressive Disorder (MDD)—suicide risk assessment
Prevention	Chlamydia screening 16-20 females
Prevention	Total EPSDT eligibles who received dental treatment services
Safety	Pediatric catheter associated blood stream infection rates (ICU and high risk nursery patients)

Users of CHIPRA Indicators

- Medicaid programs
- Other purchasers of health care
- Providers of children's health care
- The public

How to Collect CHIPRA Indicator Data

- Attestation
- Claims
- Tabulated data
  - Chart review, patient registries, EMRs
- Patient-specific data
  - Paper
  - Web portal
  - From EMRs and registries

Maine Health Management Coalition

- Maine's "Leapfrog Group"
- Collaborative of Maine providers and purchasers since 2002
- Public reporting: http://www.mhmc.info at hospital and physician-practice level
- Incentives paid to providers
- One public purchaser uses results to "tier and steer"
- MaineCare joined in 2007

Quality Counts

- Provider-based collaborative founded to help providers learn and use quality improvement
- Annual quality improvement conference
- Robert Wood Johnson Foundation's Aligning Forces for Quality grant
- Learning collaborative

Patient-Centered Medical Home Multi-payer Pilot

- MaineCare and Maine's 4 largest private payers
- 26 primary care practice sites – all but one PCCM sites
- Must have achieved NCQA Level I PCMH Certification
- Agree to strive to achieve PCMH tenets within 3 years
- MaineCare pays $3.50 PMPM.
- Rigorous Evaluation

HIT In Maine

- Most hospitals have well-developed HIT infrastructure
- Roughly 25% of primary care physicians have EMR's
- More are involved in computerized patient registries
- Many are involved with e-prescribing
- Almost none are connected to HealthInfonet

HealthInfoNet

- Statewide health information exchange
- Operational in pilot phase
  - Over 50% of Maine hospital encounters
  - One large group practice
  - Connection of lab data to Maine CDC for infectious disease surveillance

MITA Development in MaineCare

- Will go live with MHIMS (MaineCare Health Information Management System)
  - As of 8/1/10
  - MITA-certified system
  - Modular system built with COTS technology
- New claims system
- New data warehouse
- Decision support system from Thomson Medstat
- Care management platform
- Virtual medical record system from claims
- Provider portal

CHIPRA Grant Objectives

- Collect and report all CHIPRA indicators.
- Use and build on new MIHMS system to manage Bright Futures program.
- Use the indicators to drive and inform quality improvement,
- Work with HIN to develop reporting from physician and hospital EMRs on CHIPRA measures via statewide information exchange.
  - Likely to shape pediatric EMR development
- Work with MHMC to further standardize quality indicator reporting on pediatric measures across payers.
- Develop better systems to report indicators and quality measures to practices regularly and timely.
  - Who reports? MaineCare, MHMC, others?

CHIPRA Grant Collaborators

- MaineCare Office of HealthCare Management
- Maine CDC Division of Family Health
- DHHS Office of Child and Family Services
- University of Southern Maine, Muskie School of Public Service
- HealthInfoNet
- Maine Health Management Coalition
- Quality Counts

Question and Answer

- Please type your question into the chat box.
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- Or follow the instructions below
  - Send an e-mail message to: listserv@list.ahrq.gov.
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- Immediately following the Webinar, an evaluation form will appear on your screen.
- We would very much like to get your feedback; your input is extremely important to us and will help to improve future sessions to ensure we provide the best possible assistance to your agency.
- If you do not have time to complete the evaluation immediately following the webinar or would rather receive the form via e-mail, please contact Sarah Johnson at sajohnson@rti.org.
- As always, thank you!

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Comments and Recommendations for Future Sessions

- Please send your comments and recommendations for future sessions to the project's e-mail address:

Medicaid-SCHIP-HIT@ahrq.hhs.gov

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Project Information

Please send comments and recommendations to:
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