ACAP
Association for Community Affiliated Plans

FACT SHEET:

How Safety Net Health Plans Excel on Core Measures of Pediatric Care: Four Plans' Efforts to Boost Quality on CHIPRA Core Measures

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which was signed into law by President Obama on February 4, 2009, included several provisions aimed at better assessing, reporting and improving the quality of health care delivered to children and adolescents enrolled in the Medicaid and CHIP programs.

Title IV of the Act directs the Secretary of the Department of Health and Human Services to identify a core set of measures for pediatric health care quality for voluntary use by state Medicaid and CHIP programs. The initial core set of twenty-four measures was finalized and released to the public in December 2011.[1] The measures cover a wide range of health issues. Since reporting is voluntary, the number of measures collected by states varies. A notable feature of this measure set is that several come with historical performance data and benchmarks built in.

Medicaid managed care plans have historically reported their quality to states through the Healthcare Effectiveness Data and Information Set (HEDIS®), a widely-accepted set of measures of clinical quality. Fifteen of the twenty-four initial core measures are taken from HEDIS[2]. As of February 2012, 34 states used HEDIS measures or required audited reporting on a full or partial set of measures[3]. Other Medicaid plans are required to report HEDIS as part of their accreditation from the National Committee for Quality Assurance (NCQA), the organization that develops and maintains HEDIS.

This systematic reporting provides policymakers, researchers and others a library of data to help set benchmarks, assess health plan performance, and compare plans within a state and across the country. No such record of performance exists for fee-for-service Medicaid or CHIP.

ACAP-member Safety Net Health Plans have a longstanding dedication to high achievement on measures of health care quality. The high performance of Safety Net Health Plans is reflected in the fact that 5 of the top 10 Medicaid health plans in the nation, as ranked by NCQA[4], are ACAP-member Safety Net Health Plans. High performance on HEDIS measures doesn't happen on its own. Top-level performance requires an organization-wide commitment of time, resources and staff to improving the quality of pediatric care delivered to its members, which is reflected through improved HEDIS scores.

[1] Centers for Medicare & Medicaid Services. *Initial Core Set of Children's Health Care Quality Measures.* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResouceManual.pdf. Accessed May 25, 2012.

[2] Ibid.

[3] National Committee for Quality Assurance. *List of States Requiring HEDIS® Reporting for Medicaid Plans.* http://www.ncqa.org/LinkClick.aspx?fileticket=W3QVFPLsZxI%3d&tabid=135&mid=819&forcedownload=true. Accessed June 12, 2012.

[4] Association for Community Affiliated Plans. *For the Second Consecutive Year, Five of America's Top Ten Health Plans Are Safety Net Health Plans.* September 21, 2011.

This paper examines four Safety Net Health Plans that have performed at an extraordinary level on select measures included in the core quality measures set; each of these plans posted scores on certain HEDIS measures included in the CHIPRA core set that rated in the top 10 percent among all Medicaid plans that report scores to NCQA[5]. Their high performance marks these initiatives as models for other plans to follow.

Neighborhood Health Plan: Building a Culture of Quality

For each of the past four consecutive years, Neighborhood Health Plan (NHP), a not-for-profit managed care organization serving Massachusetts, has been named among the top five Medicaid plans in the country by the National Committee for Quality Assurance. (In fact, five of the top ten-rated Medicaid health plans in America are ACAP-member Safety Net Health Plans.)

This sustained run of excellence is derived in no small part from the fact that continuously improving care is embedded in Neighborhood Health Plan's DNA. "The board and senior leadership place a high priority on quality, and that has made a tremendous difference," says Pam Siren, Vice President of Quality and Compliance at NHP.

How does a plan promote a culture of quality? Function can follow form: NHP made adjustments to its organization chart several years ago that resulted in the vice president responsible for quality reporting directly to the CEO. Accordingly, top executives and the plan's Board of Directors devote significant resources to setting goals and objectives that speak directly to maintaining a high level of performance on quality metrics. "One of the overarching goals of the plan is to maintain our high ranking, and we have very specific objectives around quality" aimed at maintaining the plan's excellence, adds Siren. Committing to these goals at all levels of the organization can focus efforts on improving care.

When pursuing improvements in quality, it's natural to look at what needs fixing and work to improve it. While many of NHP's efforts fall into this category, they take a simple step that many organizations bypass: they spend a lot of time talking to providers that perform the best, and learning what works well. Siren is quick to praise the plan's 13,000 primary care physicians and specialists. "Frankly, our providers' understanding of and insight into the populations we serve has a lot to do with our success."

An example of learning from a top-performing provider came from the plan's efforts to improve its performance on measures of chlamydia screening. Early on, NHP decided that the best way to approach improvement was to benchmark screening rates in its market and see what, if anything, providers who performed well did differently. NHP quickly found that one of their community health centers improved rates of chlamydia screening through an enhancement to their well-care visit workflow: when a young woman comes in for a well-care visit, a urine sample is routinely collected. Should a chlamydia screening be indicated, the urine sample is tested (in lieu of a separate test or sample collection). This streamlined approach to getting members all recommended tests helped push NHP's rates for chlamydia screening above the 90th percentile of all Medicaid plans nationwide.

NHP has applied its strategy of disseminating best practices among its provider community to other measures of clinical quality, such as prenatal care. The plan also closely tracks members whose immunizations or checkups are overdue, and routinely provides feedback to its providers. "You can't

[5] National Medicaid 90th percentiles throughout this document are taken from *The State of Healthcare Quality 2011 - Appendix 15: Variation in Plan Performance : The 90th Percentile vs . The 10th Percentile: Medicaid HMOs. p. 177-179.* Online at www.ncqa.org/sohc. Accessed June 12, 2012.

measure and improve quality without data," notes Siren. Regular reports of children who have overdue checkups or immunizations – along with contact information – are routinely sent to their physicians' offices for follow-up.

NHP does its share by closely tracking its members who are expecting a child with an internally-developed Enhanced Pregnancy Indicator Report. The report identifies expectant mothers who may be at risk for poor birth outcomes due to age, past history or comorbid medical conditions such as substance use. NHP actively engages with high-risk mothers to ensure they are receiving the required prenatal care.

NHP also speaks directly to its members in an effort to assure that they receive recommended immunizations and well-care visits. Their rates for well-care visits for adolescents, children ages 3-6 and infants under 15 months exceed the national 90th percentile, as do their immunization rates. The plan works to meet the needs of all its members by furnishing culturally-sensitive information and helps keep needed checkups and immunizations present in the minds of their members by sending refrigerator magnets to parents shortly before a child's birthday. "It's a nice way to wish a child and their parents a happy birthday – and it is a helpful reminder for them to go to the doctor's office for a well-child visit," says Siren.

The plan also aggressively leverages its social care-management function to help connect members to their physicians. "We're figuring out what activities or supports we need to get kids into an exam," adds Siren. "Much of this comes from understanding who we serve and understanding the challenges they face. Many face transportation issues. Others may have a parent or grandparent they are caring for in addition to the child."

In addition to educating providers and their own membership, NHP also works to provide support to the community it serves; the organization's mission extends beyond promoting the health and wellness of its members and includes the broader community. "Sometimes having one of our medical directors write a public service column in a local newspaper about immunizations or prevention is the most effective approach."

This multifaceted approach to quality reflects an organizational conviction that everyone deserves high-quality care. "There's no reason why kids who get care through public programs shouldn't have the same outcomes as those who are privately insured," Siren says. NHP is apportioning significant time and resources to identifying and eliminating racial and ethnic disparities in care to assure that all its members receive the top-rated care that NHP and its providers have devoted themselves to giving.

Denver Health Medical Plan: Using databases and decision-support tools to promote quality

Denver Health Medical Plan, Inc. is a subsidiary of Denver Health, one of the nation's leading integrated public health care systems. The plan, which serves low-income populations in the Denver metropolitan area, has consistently been among the top-performing Medicaid plans in the country on measures of childhood and adolescent immunization, and has also posted impressive rates on measures of body mass index (BMI) assessment.

The linchpin of Denver Health's high performance on immunization measures is a groundbreaking vaccine registry called VaxTrax. The database, implemented in 1995, helps the plan identify which of its members are in need of recommended immunizations and prompts its providers to perform outreach.

"We can influence quality most directly by looking at the basic work that occurs every day in our federally-qualified health clinics," says David Brody, M.D., Medical Director, Denver Health Medical Plan. When a child visits a Denver Health clinic, the VaxTrax immunization registry is routinely queried as part of the standard visit workflow to determine whether the child is up to date on his or her immunizations. The database will flag children who need an immunization and prompt the staff via a pop-up message. VaxTrax includes an algorithm that serves as a clinical decision-support tool, providing a standing order for a nurse to provide routine immunizations in a timely fashion.

As an innovative integrated health system, Denver Health operates 14 school-based clinics where VaxTrax is in use. The medical plan supports back-to-school registration into these clinics so that children can be seen in either a school-based clinic or one of its eight Federally Qualified Health Centers. Dr. Brody notes that older children in particular are more likely to receive their well-child visit and immunizations in the school-based clinics.

To ensure that the database is as current as possible, VaxTrax is linked to the state's own immunization database. This helps providers who have access to state data avoid duplicative immunizations when a child receives care outside the purview of Denver Health Medical Plan's network of providers.

The implementation of the database, coupled with clinical decision-support algorithms, paid immediate dividends. A study by Denver Health researchers found that the implementation of VaxTrax improved immunization rates in 2-year-old patients by 46 percent, and immunization rates in patients less than one year old improved by 26 percent[6]. As a result of this initiative, countless vaccine-preventable diseases were avoided. The Joint Commission recognized Denver Health for this improvement with a Codman Award for quality in 2006—one of only two such awards made in a ten-year period. Since its implementation, the plan has expanded the database and clinical decision-support tool to include vaccinations for adolescents and adults.

Denver Health also expanded their decision-support capabilities to help providers provide recommended body mass index (BMI) assessments and nutrition counseling in line with the core quality measures. The high performance of Denver Health's providers on this measure comes from the simplest of quality improvement initiatives: the checklist. Prompts for nutritional counseling are standard on Denver Health's paper encounter forms. Using the same systems and principles that powered the VaxTrax database, electronic encounter forms are programmed such that when a medical assistant enters height and weight at check-in, a BMI and percentile based on age and gender are automatically generated. This approach helped propel Denver Health's performance scores on BMI assessment and nutritional counseling past the national 90th percentile for all Medicaid health plans. The use of prompts has also helped the plan to post rates for chlamydia screening in excess of the 90th percentile.

The use of databases and clinical prompting represents a shift in the way that doctors deliver care to their patients. Several large hospitals and integrated health care systems have had high-profile struggles in bringing technology into the doctor's office. But one reason that Denver Health Medical Plan has succeeded is engaging their in-network physicians throughout the process: from design through implementation to evaluation.

[6] Improving pediatric immunization rates in a safety-net delivery system. Melinkovich P, Hammer A, Staudenmaier A, Berg M. *Jt Comm J Qual Patient Saf.* 2007 Apr;33(4):205-10.

"The community health clinics and managed care share the same focus. We work on improving care by collaborating in quality improvement workgroups and by engaging the clinics in our interventions," says Mary Pinkney, R.N., Denver Health Medical Plan's Director of Quality Improvement. The workgroups perform much of the nuts-and-bolts work that drives quality improvement over the long term: clinic-level review of quality data, review of point-of-care workflow to ensure that providers are prompted to perform needed routine care and counseling, and assessment of resources and responsibilities at both the clinic and health plan level and apportion them in a way that gets the most of out of a limited set of resources.

"The important thing from the perspective of Community Health Services is getting children in the door. If we can do that, our systems ensure the children receive all the services they need," added Stephanie Phibbs, MPH, Quality Improvement Coach at Denver Health's Department of Community Health Services. "Managed care is a real partner."

"We're working hard to make this a well-coordinated process," adds Brody. "In the past, we've done our things and the clinics have done theirs, which has led to some duplication of efforts. We've come to recognize that all of us need to work together to maximize our resources in the best possible way."

Health Services for Children with Special Needs, Inc.: Improving Care, One Member at a Time

Health Services for Children with Special Needs, Inc. (HSCSN) is a Washington, D.C.-based care coordination organization that serves individuals with disabilities up to 26 years of age who receive Supplemental Security Income (SSI) or are SSI-eligible in the District of Columbia. To ensure family continuity of coverage, HSCSN also coordinates care for children born to its current enrollees. HSCSN employs clinical and social case-management strategies to improve enrollee health.

A unique feature of HSCSN's model of care for its enrollees is its intensity of outreach: each of HSCSN's more than 5,000 enrollees is matched to a dedicated care manager. As the plan is committed to serving children in need of more intensive and more frequent visits, care managers at HSCSN have a closer relationship with their assigned enrollees than is the norm. This high-touch model has propelled HSCSN to score above the national 90th percentile on a range of HEDIS measures, notably well-care visits for children and adolescents. They have also scored well on measures of dental care, a crucial service for children and adolescents with special health care needs.

"Our front-line staff—care managers, customer care representatives and community outreach representatives—are where we find our resolutions to barriers of care," says HSCSN Director of Quality/Accreditation Constance M. Yancy, MBA, BSN, RN, CPHQ. "We serve a high-risk, high-needs population, and establishing a personal connection with our enrollees drives our success in assuring positive outcomes."

HSCSN's high performance on well-care visit measures stems from a concerted effort among staff, practitioners, providers and community partners. It starts with an assessment of the care managers' workload. The plan found that its care managers were spending a lot of time scheduling well-care appointments. HSCSN conducted a pilot study to see whether enlisting customer care representatives to perform routine scheduling of well-care appointments would free care managers to devote their time to the more complex clinical and social case management needs of the enrollees. Appointment setting strategies were paired with automated phone calls and reminder cards to promote compliance. Enrollees with no-shows are flagged and sent to the care manager, who uses additional care

management approaches to encourage the enrollee to visit his or her provider for well care. HSCSN actually has a unit devoted to finding and contacting hard-to-reach enrollees.

Care managers' activities are guided by a report that details where each of the HSCSN enrollees on their case load stand with respect to preventive care. Due and overdue immunizations, checkups and dental visits are detailed in a color-coded work plan that is updated nightly. Once updated, the work plan automatically calculates the next due date to help the care managers proactively coordinate care. The automated data collection and color coding of this report has led the organization to nickname it "the Magic Report."

The close relationships between HSCSN's care managers and their enrollees increase the impact of care coordination. Care managers make an effort to meet each of their enrollees or their caregivers in person. This face-to-face contact does more than add a human touch to HSCSN's care management efforts: it is also an opportunity to provide support materials to the parent or caregiver. These include growth charts for children under two, social support resources and calendars pre-populated with key dates, appointments and reminders.

Care managers also help parents of special needs children coordinate a higher-than-usual frequency of medical and behavioral health specialist visits, including rehabilitative therapy and equipment appointments. "Many of the children we serve are cared for by young mothers who sometimes can confuse sick visits or specialist visits with well-care visits," adds Yancy. "If you have a special needs child and you've been to a specialist six times this year, you might figure the preventive care was handled at one of those appointments. That's not always the case."

Behind the scenes, HSCSN works with the providers in its network to boost well-care visit rates. HSCSN offers network providers individualized data on their HEDIS scores and their performance against national benchmarks. "We work closely with our providers to make sure our enrollees get in for their visits," Yancy says. "If patients aren't showing up for their well-care visits, sometimes our providers have insight on why." Some of HSCSN's larger providers hold open office hours for walk-in appointments. Many providers also make extensive use of electronic medical records that feed into one centralized database from all of their affiliated clinics and offices. This allows data collection around well-care visits to be conducted more efficiently. This promotes follow-up for missed appointments on both the plan and provider side.

For adolescents, who can be a more challenging and difficult-to-reach group than children, HSCSN has found that outreach efforts that speak directly to adolescent enrollees on their own terms can have a higher rate of success. "Our success stems from developing a rapport between a care manager and an adolescent member," notes Yancy. By the time a child has reached adolescence, going to his or her parents doesn't always produce results. HSCSN conducted a series of focus groups with its teen and young adult enrollees; the groups' feedback led to the plan offering incentives that appeal more to adolescents, such as movie tickets and iTunes gift cards. The plan has also forged strong relationships with area schools and school-based clinics to support access to service. The plan regularly schedules events and activities at area schools that promote the importance of prevention.

HSCSN also applied its intensive care management model to dental care. While HEDIS specifications call for an enrollee to visit the dentist once per year, HSCSN set the bar higher: its internal goal is two dental interventions per enrollee per year. Yancy credits the high performance of the plan, in large part, to having a robust network of dental providers. Many of their partner health clinics have dental facilities on site, allowing enrollees to visit the dentist and the doctor in a single location. Their dental

network administrator also has emphasized hiring providers who have specific expertise in providing care to the children and young adults with special needs.

The care managers themselves also found an elegant solution to boost dental visit rates for HSCSN enrollees: setting up their face-to-face meetings at the dental office. The plan also empowered the care managers to award 'on the spot' incentives to promote compliance. "Only our care managers would have thought of simply saying, 'See you at the dentist,'" says Yancy. Care managers have completed face-to-face meetings and other well-care requirements in a single visit. "It's proof that our best solutions come from our front-line staff."

Central California Alliance for Health: Aligning Provider Incentives to Boost Performance

The Central California Alliance for Health is a publicly-operated County Organized Health System that serves more than 200,000 members in Santa Cruz, Monterey and Merced counties in California. The plan has worked in close collaboration with its community of healthcare providers to promote a culture of continuous quality improvement.

The Alliance has in recent years posted HEDIS results in the 90th percentile of all health plans on a wide variety of HEDIS measures, including childhood immunizations, prenatal checkups for expectant mothers, BMI assessment and nutritional counseling.

David Altman, M.D., Associate Medical Director for Quality Improvement at the Alliance, ascribes the high level of success on a broad spectrum of clinical measures to building close relationships with physicians, and working together to develop performance-based incentives that promote high-quality care. The provider community was engaged in program design from the beginning. "We have several layers of physician input, ranging from a Clinical Quality Improvement Committee comprising network providers to a physicians' advisory group that talks straight to leadership," Altman noted. The plan's Board of Directors includes six seats dedicated to representatives of providers and provider groups.

The incentives came out of a program that rewards providers based their performance on a wide array of criteria, including outcomes measures included in the HEDIS set. Doing so aligned physician incentives directly with the plan's incentives from the state to demonstrate a high level of performance. "Our physicians let us know that these incentives caught their attention, and moving to care-based incentives—aligning physician incentives with the quality goals of the plan—made a lot of sense. This way, all of us were pulling in the same direction," explained Altman. The incentives also seek to promote the ideals of the patient-centered medical home. The program starts with a basic incentive for all physicians that is paid if they report their results. Physicians who submit data receive a detailed, quarterly report that provides them an overview of the practice's performance on specific measures of care. The practice's quality profile includes:

- the proportion of children and adolescent patients eligible for a well-child visit who came in for a recommended checkup;
- the percentage of patients whose body mass index (BMI) was calculated;
- the percentage of patients who received recommended cervical cancer screenings; and
- a range of other HEDIS measures, including measures of diabetes care, asthma medication management, and breast cancer screening.

Practices are given their absolute rate of performance, and also their percentile and quartile relative to other practices. Their resultant incentive payments are also detailed on their profile, and sent to physician offices every quarter.

Addressing factors that led to childhood obesity was a high priority for the Alliance. Accordingly, the plan paired its BMI assessment measurement and incentive program with its Healthy Weight for Life program, the centerpiece of the Alliance's efforts to combat childhood obesity. This program, aimed at children and teens ages 2 to 18, helps children develop healthy eating habits and live an active lifestyle. Physicians would receive incentives for referring obese children—whose BMI was in the 85th percentile or higher—to the program, and a second incentive payment for a follow-up visit.

This strategy was paired with a member incentive program that featured gift cards to department stores for parents of children who completed Healthy Weight for Life. The strategy paid off, as the Alliance posted HEDIS scores above the 90th percentile on measures of body mass index assessment and nutritional counseling. The Healthy Weight for Life is but one part of the Alliance's member incentive program, which also includes incentives surrounding prenatal and postpartum care, kept appointments, and diabetes and asthma care.

"We looked closely at how the program has done – and it's been a success – but we think there are steps we as a plan can take to help our physicians improve their performance," says Altman. This includes reviewing their own data collection efforts and incorporating new areas of emphasis – measures of asthma were incorporated in 2011 and the plan developed a Healthy Breathing for Life program. The Alliance also incorporated the providers' own encounter forms into its data collection process to streamline quality reporting, reduce duplicative paperwork and help their network physicians do what they do best – deliver top-notch care.

Safety Net Health Plans Drive Quality Improvement

While the details in each of the four plans profiled here differ, their efforts draw on themes common to high-performing plans. They include a commitment to quality that imbues all levels of the organization, data systems and support that help guide quality improvement efforts, fruitful relationships with providers, and the recognition that many solutions come from front-line providers and care managers who interact with a plan's members every day.

High performance on HEDIS measures—and the entire CHIPRA core set—is laudable in its own right, but it bears noting what this high performance means. It means that children don't come down with a case of diphtheria or whooping cough because they are immunized, and their parents don't need to take time off to care for them. Pregnancy comes with fewer complications. Children lead healthier, more productive lives. Ultimately, better health is what we want out of the health care system. And it is what Safety Net Health Plans work every day to deliver.