

2011 AMCHP and Family Voices National Conference: Child Health Improvement Partnerships: Benefits for MCH Programs

02/15/2011 Omni Shoreham, Washington, D.C.

JUDITH SHAW: So hopefully we'll get a few more participants but I wanted to welcome you today. My name's Judy Shaw. I'm on the faculty and the Department of Pediatrics at the University of Vermont, direct – what's called the Vermont Child Health Improvement Program. So you are at Child Health Improvement Partnerships Benefits for MCH Programs. I am going to, in the interest of time and the fact that you've probably heard this repeatedly about the evaluations, not re-read what you've probably heard multiple times, but to suffice it to say that there is conference evaluations online for CME, for CEUs and all of that. You need to complete the online survey and we also have evaluations on your seats that we would appreciate you completing and handing at the back when you leave this session.

I'd like to introduce our presenters. I will keep their bios brief. To my right, first of all, is Chris Kus. He's the Associate Medical Director of the Division of Family at the New York State Department of Health. He provides leadership for New York State Child and Adolescent Health activities. I'm not going to go on with degrees and all of that, just to keep us focused on time.

Breana Holmes is next. Is the Maternal Child Health Director in the Vermont Department of Health. She was a practicing pediatrician for 11 years in Middlebury, Vermont where she was a physician leader for her group and Chief of Pediatrics at Porter Hospital and we're very pleased in Vermont to have Breana in that role.

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And last is RJ Gillespie who's the Medical Director of OPIP and a practicing pediatrician in Oregon. And all three of these people, along with me, will be talking about what's near and dear to us, is how to improve the quality of healthcare for children.

Now interestingly I didn't realize what the subject of the plenary was prior to putting this session together but last week we e-mailed and I said, "Well, what if we tried to do it without slides or we just did a brief overview and we just get engaged in a dialogue and a conversation?" I didn't say tell stories, so I won't stretch the truth, but we decided that on a Tuesday when you've been lectured at and seen multiple PowerPoint's we would try to keep those to a minimum but use them if we needed to to supplement the message that we wanted to deliver. So we were ahead of the curve as far as the telling stories and just engaging in a conversation. And when we've done this workshop before, in fact, Paula Duncan had done it with me a couple years ago, she just had people pull up chairs into a circle and we sat and an amazing conversation.

So we're hoping to engage you in a conversation but I unfortunately have a few slides just to set the context of the conversation and to give you a brief overview of what we mean by improvement partnerships. So what we'll talk about today is I'll go briefly vCHIP the program partnership model, talk about the national network that we've developed, that we would any of you in the room that are not a part of it or have a state that's interested joining in on us and then we'll give some perspectives from some of our improvement partnership states.

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So I want to start by saying my story is Vermont children are among the healthiest in the nation. And I think there's a reason for that. There's a lot of things that are going on in Vermont; first of all, you could fit the entire child population probably on a block in L.A. or a block in New York City. It's a very small state, but what I'd like to say is that we can serve as a test site. When you do a research project or a study, you often started in a small place, work out some of the kinks and then spread it. And I think that's what you'll see what we've done with this improvement partnership model is that we've started it in Vermont but we're now – other states are taking it on and we're massaging it and taking a look at it. So why is it Vermont still – this is actually 2009, we dropped to a grade C but we're still number one in the country for the rates of preterm birth. We hold the rank; this is from the United Health Foundation, of number one healthiest state in the country. And this is from the Commonwealth Fund Scorecard 2011 and it was just released. If you want to take a look at it it's a great place to look and see where your state ranks and see where you state is. And Vermont had been number one; it's now down to number three, but we're in the top cortile for overall health of the population. And I'd like to say, and also this is actually the Children's Healthcare Performance measures, I'd like to say it's because of vCHIP but it's not just vCHIP. It's the collective collaborations and partnerships in the state that have contributed to improve children's health outcomes.

And so vCHIP was started in 2000 when I moved to Vermont. So what's the story behind vCHIP? The story behind vCHIP is back when I was sitting at Children's Hospital in Boston in the 1990s,

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Vermont came together to look at preventive services, the guidelines for the Medicaid population. They came together, they brought clinicians, families, public health workers, everyone together ensures to come up with agreed upon set of guidelines for preventive services for Medicaid and they completed it and they took a look at it and they said, “Why is it this just for Medicaid? Why not have this for all children in this state?” And then the next question was, “So we’ve got these guidelines, how do we know we’re implementing these guidelines? How do we know we’re doing this?”

And that’s where vCHIP came, was the brain child of a lot of very creative people in Vermont who said, “You know what? How do we know the care that we are supposed to provide, we are indeed providing? Let’s start a child health improvement program and let’s take a look at that.”

So that’s where vCHIP started. I’m not going to go into the details but suffice it to say that if you build it they will come and some of you in this room have had that experience, is that once you put a name and a logo and mission statement together and say, “I’m here to help. I’m here to help you assure that the care you aspire to give is indeed the care that you’re providing and we will help you to do that.” We became barraged with a lot of different projects and took on a lot of projects. And I’m not going to go into the details but to say that we’ve taken on a lot in this state.

Here’s some of the additional projects just to make sure people aren’t confused. vCHIP does exactly what I just said. We’ve also

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taken on some evaluation work because we're based at the University of Vermont; most of us are health services researchers. We do also evaluations. So we've diversified. We don't just do quality improvement projects. We've added in some evaluation components to work collaboratively with our Medicaid program, with our public health program.

We work with almost all the pediatric practices, all 39 of them in the state. Like I said, a block in L.A. and a block in New York City, yeah. And family practices; we have 106. We work with the majority of family practices that serve children.

These are our completed projects, just to give you a sense of the timeline. We really are active in completed projects, have taken on a lot and we have quite a few projects going on in Vermont. Now thing about 39 practices, roughly 40 family practices that serve kids and look at the number of activities that our program has going on in that. This is our funding; people are very interested in our funding. I'm not going to go into detail but it certainly has grown over time. We've attracted external funding. We've worked on drawing down the Medicaid match for our activities.

So vCHIP was moving along quite swimmingly and doing a great job and then somebody asked me to come teach them how to develop a vCHIP-like program. And then another state asked to do that and another state. And we had no funding to support us going around and teach about these programs. Luckily, Ed Schor from the Commonwealth Fund saw the benefits of what we were doing and funded us to support recruiting states to try to replicate the

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vCHIP model and when I saw one of my colleagues put up a slide saying we're replicating the vCHIP model we realized it was time to call it something different, rather than the vCHIP model or the vCHIP-like program. So we call it an Improvement Partnership. And what is an Improvement Partnership? It's a durable regional collaboration of public and private partners that use its measurement based efforts and a systems approach to improve the quality of children's health care. Key words: durable, regional or state based, depending upon what you're talking about, public and private, and measurement so that component of understanding how we're doing and then working on improving the care and applying the systems approach.

So why are states doing this? What is it that's making many of these states develop this? They're interested investing in children's health care. The recognition and embracing of the local expertise and I think if you take one thing away today, take away the fact that what we've been able to do and the stories you're going to hear are taking the expertise that you have in your region and your state, embracing it, and bringing it to your region or state. My story, my elevator statement about vCHIP is when I came to Vermont there were a lot of extremely talented, smart, wonderful people at UVM doing work nationally. They were not giving back locally. They were not bringing their expertise back locally. So what we've been able to do by vCHIP is I'm not taking researchers and having them do all their work in Vermont, but I'm taking a piece of their brain and making sure that they sit down with Breana Holmes, who's our MCH director and our commissioner and our

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Medicaid director, to bring their expertise to how things work in this state. And I think that's the most important.

And the last piece is that innovation and success is often not connected or broadly disseminated. So you'll find pockets of excellence. How do you distribute how? You'll also find redundancies, duplication in your state. How frustrating it is when you apply for a grant and you find out Public Health has applied for the same grant or is writing the same grant? It's not a perfect situation; we don't get away from that completely but we really try to coordinate our efforts.

So improvement partnership development. Here's the story: vCHIP got started, that first state that invited me to come was Utah. UPIQ, the Utah Pediatric Partnership to Improve Healthcare Quality. I love their acronym. UPIQ means you pick clinicians, what's important and what you want to work on, and we, as the improvement partnership, will help you think about the tools **** strategies and ways to do it. We will bring our expertise, you tell us what the issues are, what's important, what are you struggling with.

Then along came Envision New Mexico and then a lot of other improvement partnerships. So Minnesota, West Virginia, Arizona, Oklahoma; I don't have all them up here ****. oCHIP just changed to BEACHON and I don't know – I can't remember their acronym and I don't have their logo, so I haven't put it up there. And then recently, in the last year, we've got OPIP, which RJ's going to talk about. The Oregon Pediatric Improvement

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Partnership. And Paula Duncan, my colleague, and Patricia Berry just went to Indiana to do a site visit. What we often do is come and talk about the improvement partnership and what other states have accomplished as people explore an area – the possibility of developing one. And when they went to Indiana, not only were they – did they have Medicaid and the Health Department and all the right players around the table in a very organized two-day session, they'd already developed a name and a logo. So if you see anybody from Indiana you can say CHIPIN because that's their name is CHIPIN.

So what do they do? I think we've talked a little bit about it, developed and test tools and strategies. So how can I help? How can I help you do a good – deliver good care? We go out and research the tools and strategies. Breena says, "I want to focus on improving our immunization rates. I want to focus on improving lead screening." vCHIP can help look at what others have done, what are the tools, strategies, and materials for doing that. We serve as a resource for improvement, we translate knowledge. So we'll help bring in engaging local and national experts. We disseminate findings and the last piece is serves as an honest broker.

If you think about it, if you're in state government, you regulate, you set the rules, the set the policies. If you're practice, you're delivering the care. Who's the broker that goes between those? We're not the regulators; we don't deliver the care, but the improvement partnerships serve the intersection between those two groups.

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Where are they located? Very quickly, anywhere there's strength in pediatrics. Our program's based at the University of Vermont, at a university but as you can see some are based in a P-chapter, some in Medicaid programs, some in Departments of Health, and Marc Waisman's here from D.C.. There's is based in a children's hospital.

And the last slide is as we begin to come together, all of these states. And I haven't added Indiana up there yet. As we begin to come together, the state said let's create a network so that we have a place to share what we're doing around quality improvement, around systems improvement in the states. So a couple years ago we came up with NIPN, which is the National Improvement Partnership Network. So what does NIPN do? NIPN serves as a convener; we do the same thing that an improvement partnership does in a state but on a national level. So we convene the states to come together to talk about the work that they're doing, share problems, share strategies, share tools and materials. So if one state is working on maintenance and certification on an asthma or obesity project, we don't have to duplicate it in another state; we can borrow and share strategies.

So the NIPN group meets monthly on a conference call; we have an annual meeting, which is going to be held prior to the Academy Health meeting in Seattle in June. If anybody's interested in coming to that meeting, we're certainly are open to anyone who would like to attend our national NIPN meeting and we talk about activities and work on synergies across the various states.

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So that's a quick overview of improvement partnerships, what we're talking about, what the NIPN network is and then I'm going to turn it over to my colleagues to give you a little – their stories about what they've done in their states and then I think we'll open it up for questions regarding where are you, are you doing this, are you interested in starting this, what role might you play in your state or on a national level in the work that we're doing.

So I'm going to turn it over to Chris.

CHRISTOPHER KUS: Thank you. I'm Chris Kus, Pediatrician in New York State and we're actually an improvement partnership wannabe. And I'll tell you why, but we've taken a lot from the lessons and have used it but Vermont's a small county in New York State and I spent 10 years in Vermont so I can say that. And I do have a little bit of PowerPoint but I'm going to go really quickly through the part of it and then I figured I'd tell the story that I like – and I'm looking at people and I don't think they've heard it but it has some relevance to what we're doing and it's a story about a hot air balloon that David Satcher [sp] told awhile back at one of the MCHP meetings I think.

And it's a good day; it's a sunny day. Let's take New Hampshire and there is a Maternal and Child Health Program manager in New Hampshire who is a hot air balloon enthusiast and person decides that geez it's such a gorgeous day, my desk is not too full, I'm going to take off this afternoon and take a ride in the hot air balloon. So she gets into the hot air balloon and she takes off and

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is gone for about an hour and a half and realizes she doesn't know where the heck she is. So she's being a thoughtful person, she decides that well geez now if I lower the balloon down and I find somebody maybe they can give me bearings. So what she does is she lowers the balloon down about 20 feet and she sees this thoughtful guy in a country path walking and she yells down to the guy and says, "Hey! Can you tell me where I am?" And being a thoughtful guy he thinks a little bit and he says, "You're in a hot air balloon 20 feet above the ground." And she says to me, "Geez, you must be some kind of statistics person or somebody that does data." And he says, "Yeah, actually I do some epidemiology for CDC." And he says, "Well how did you know that?" And she says, "Because you make good observations, you're technically correct and you're of absolutely no use to me." And the guy on the ground says, "Now, now, wait a minute. So you must be some kind of bureaucrat or a program manager or something like that." And she says, "Yeah, actually I am a program manager for Maternal and Child Health Program." And she says, "How did you know that?" And he says, "You don't know where you are, you don't know where you're going and you're blaming me."

I mean, I think that's part of the quality improvement is really the importance of measurements. A lot of times when you go to practices they say I'm great at this and then if you really measure it you got a little ways to go. So we actually got Vermont – New York got involved in this through the money that came through Commonwealth; a small amount of money. In New York State – in Vermont – when I worked in Vermont, you go to the meetings and you see the same people at the meetings. In New York you've

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got these big agencies that we were trying to get a sense of can we get people on the same direction in terms of improving child health and of course nobody wants to do it unless you get a small grant that says that you have to do it. So that's what we did. And what we ended up doing is with our improvement partnership we did it with chapter – there's three chapters of pediatrics in New York and it's a whole district by itself – but we did chapter three, which is the western part of New York and got them involved to do a child development – this was just before the guidelines were coming out about developmental screening, so we were right about that time.

So we got the chapter involved, we had our early intervention program, which was in the health department, we had our health insurance program, which is in the health department at the table, and we had families at the table; Ruth Walden, the President of Family Voices used to work at the New York State Department of Health. And we did a project and the project – that project was to focus on improving the capacity of pediatric practices to do child development surveillance and screening and you were using the developmental screening and autism screening later on with the spread of that. And this talks about way back when we did it. The first one is – was in way back in August 2005, was where we had six to seven practices, did the learning collaborative model from IHI, the model for improvement, got practices together and people really had – it's hard to get people across but we bought the developmental screening tools for them. We were using – having them choose whether to do the ASQ or the Peds and we gave them training on the model of improvement PDSA, Plan Do Study Act, rapid improvement part, and we went from – this was an easy win

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because at that time nobody's doing double standardized developmental screening. So you start with almost zero and if they start doing it, you look a little bit better. And then from that we use that same kind of model. We could have had a good logo if we really had a partnership, but we started out calling ourselves the Empire State Child Health Improvement Project Program. So ES-CHIP. And so the people who were in health insurance talking about ES-CHIP were mad at us, but we still did it. So we've gone on using that model and I think the part for us is I'm still trying to get a commitment.

We're based in Albany; we have a medical center there. We have a public health school. We have the Academy of Pediatrics who has become an ongoing partner with us in doing improvement partnership, improvement activity. But to get people to -- you got to have some money to make some money and to get the grants we're still working on that part of it. Now we have a new governor and a new commissioner, so maybe can have that discussion. But the things that's really been positive and I've continued to participate in NIPIN because my staff hears it all the time. I'm a big believer in improvement partnership because you're really leveraging people to try to get them on the same direction of how do we decide as a state where we want to put our efforts in terms of child health improvement. We've actually incorporated it.

Our children with special needs -- one of our goals is improvement of health care delivery for kids with special health care needs. A couple of the people that participated used the improvement model

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in managing their programs. So we've developed staff that have quality improvement in the mind and really make the case that that's part of public health and that's actually a critical part of public health.

Just to give you a sense that we are talking about system development, this is taken from Ed Wagner the care model. Because when you initially talk to practices they say well we can do that tomorrow. Well, we know it's a system change in the practice and it's usually the nurse coordinator or the office staff that really make things happen. So we try to give people a sense of how we're dealing with systems, but just talks about the model for improvement, the collaborative model and make these little changes, which is the biggest thing; everybody wants to change things overnight. And so for them to think about doing the change and then seeing what makes a difference on a small scale is one of the things that takes a long time for people to get across.

So these are kind of the lessons we've learned. For developmental screening, it did improve the numbers and we've gone on to do a spread of it. What we've done recently is we did a spread of child development and autism screening using champions from each of the three chapters in New York. So the partnership of pediatrics is critical because they help recruit the practices. They get it excited about it and then that becomes part of what their message is. So, in our first one we talked about chapter one being critical, but now we have three chapters involved.

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It is interesting for practices who never get together to all of a sudden find the advantage of it. So we heard about that but I think one of the big parts that they found helpful is when we were going through the child development learning collaborative, it was the time the academy was going through Bright Futures and there was the statement about the 30-month visit and we should do screening at the 30-month visit. Well we had Medicaid at the table and so they said we don't get paid for it and within the next two weeks our Medicaid people put out that that was going to happen. So they felt some power that they -- besides from a State Health Department point of view, you're looking at system barriers that you can deal with that could really help practices. Our challenges are they take time away. How do you get people to stay connected on a monthly basis? Let's see, I don't need to go through the rest of this part.

The other things we've done is we embedded this in some of our other work. We did a learning collaborative relative to asthma in school based health centers. I'm a big believer that school based health centers is a good place to deal with chronic disease and we did that. Actually, our asthma program now is really a quality improvement effort. So I think the long and short of it is, I'm hoping to become like vCHIP in New York because it just is a very powerful thing to get people to talk about the same thing and to commit to it and then really use the idea of that we're measuring change and we're able to deal with that change with a few more practices than there are in Vermont.

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BREENA HOLMES: I do not have any slides. I'm very dutiful when folks they don't bring slides. I didn't bring slides. I thought I would echo a few things that were said and then really looking forward to the interactive part of this because I have two roles I can play today. One is the public health MCH director component and **** of vCHIP, but I was also one of the star practices for the full 10 years of vCHIP's work at working with providers at the real patient level.

So, couple of things to echo really quickly. One the existing worlds between people who sort of know the research and have the background, and work at universities, and then the providers. That bridge is exactly what vCHIP does and I bet that's scalable in larger states, which is just that there's a whole group of people seeing patients and having been one of them for a very long time, you feel very disconnected from quality initiatives, research and despite your best efforts. And your AAP chapter is also a key component to that link and hopefully in your states that's kind of a high functioning group. I think in most states it is.

So what I wanted to tell you was the youth health story just to play out all the components. When you see that slide that describes who are the players in vCHIP, that we have Medicaid, we have the private insurers, we've got the university, we have AAP, we have the health department. How that works real-time is that before I started the Maternal Child Health job I worked in adolescent health and I started working with the youth health team, which is Paula Duncan, Barb Francowski's team. And so just as an example of the vCHIP work we looked at Chlamydia screening rates in our

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state. Now I would bet it's similar in your state, too. Pretty low for what a public health goal would be for the long term implications of undetected Chlamydia in your teenage girls.

So the private insurers care very much about that; that's a **** measure for Blue Cross Blue Shield, CIGNA, and they were very concerned but didn't have a clear sense of why we weren't doing a better job. The private practitioners felt that they were asking about sexual activity and getting an answer, often, "No, I have not had sex." And then opting not to screen. So they felt reasonably good about their adolescent health skills, their ability to ask that question and the decision not to screen after getting an answer.

Health department has a whole world of health surveillance and a whole Chlamydia department that knew very much that way more people were having sex than were admitting in the provider office and that in public health worlds and in cities, in Vermont – but you know in the city, when you go – I trained in Seattle and in Seattle when you learn about sexually transmitted infections you just screen everyone, but Vermont has that – the private practice way and 14 year olds aren't being screened for Chlamydia. So that conversation began as a learning collaborative. It was like pure heaven for me in adolescent health. We found with the help of our private insurers and Medicaid, the high volume adolescent practices in our states, the way to go at it, the people that really were seeing the teenagers and that's available. So we brought those six practices now, again, small numbers, but six high volume practices into one room for a day. We brought in our private insurers and they sat at their own by themselves, but they were

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fascinated to hear that when you screen for Chlamydia it goes on the Explanation of Benefits to the mother, EOB. And what we learned was that some private insurers call it lab collection. Some people just say it's Chlamydia screening and in Medicaid they don't create one of those. So we were able to teach each other that barrier, because private practitioners carry the belief that it would no longer be a private but they didn't drill on it; they didn't have time to drill down and say, "Which insurance companies are saying we just screened your daughter for Chlamydia?" Or son.

So that was a very effective part early in the morning, then we went through how you talk to kids about sex and we have Barb Francowski with us. Those of you who know her, know she's really a sex expert, adolescent health physician. And we did role-play; we had a lot of fun talking about establishing confidentiality, what does that really mean. You know, 2011, how do you talk to folks about sex and then we pulled **** behavior data – that was my role – to show 60 percent of the high school seniors in your area, we did it by the school districts of the practitioners where they had their practices. So we could say to Orange County, 60 percent of your seniors are having sex. So the fact you're screening two percent of the kids means somebody's not telling somebody something.

And that was really fun because there was just – when we first asked folks why aren't you getting a higher rate of "Yes, I'm having sex," there was that pediatrician answer. Just I've known this family forever and she's – we have a great relationship and she's not having sex. So it was data, it was private insurers; it was

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sex experts in how to talk to teenagers. We used it as an opportunity to bring in our health department people, which the whole Chlamydia department came. You know, there's three people that – and they were able to talk about cost and we didn't solve any problems that day but we just created an initiative together to change that number and I was glad Chris – because I don't have slides that PDSA. So this was – I'm going to just tell you this learning collaborative was last March and every single practice's already increased their rate of screening and they're all doing it differently. Fund system change in offices, which is some people are just getting urine on all kids and then asking the question and then the urine gets tested in the yes groups. Some people are screening everyone and overcoming the barrier of the cost and the insurance. And some people are still doing the coming out of the room and peeing after they find out that the child is sexually active.

But we're having ongoing – we have monthly calls to find out how it's going with *****. And that's one teeny story because within that I am so tempted to tell you all about how we're looking at yearly visits for adolescents because that's another ***** measure that's also a big challenge in our state and we're also looking at immunization rates among teenagers and we bring the health department immunization folks to that table. So I could go on and on, but I wanted to stop there and let RJ speak and then hear some thoughts and questions.

R.J. GILLESPIE: So I wanted to talk just briefly about Oregon's story. We are eight months old as an improvement partnership, so it's kind of a short

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story, and then I'll talk about a couple of our projects, but I think we had our technical assistance visit from Judy and Paula last February and then really got on our feet in July. I think this story started in 2007 though, when a couple of things happened. I was a member in Portland of a large independent practice association, 110 pediatricians and 19 different practices, and we had banded together in early 2000, 2001 to do bulk purchasing and contracting and that kind of stuff to remain competitive with the University and with Kaiser and realized with managed care kind of going out the door in our area that we needed to do something different to provide a benefit to our members. And we decided that quality improvement was a good way to go and that clinical integration was a good way to go in terms of moving forward. And so we kind of formed an ad hoc committee. I was asked to actually just be a part of the committee and when somebody realized that I had a Masters they figured that I must know statistics, so I must be able to do quality improvement, which I still don't know how they came to that conclusion. Taking a class in statistics isn't exactly the same as knowing it, but nonetheless.

I was asked to lead the quality improvement stuff and within a couple of years we were actually able to rip through four pretty big quality improvement initiatives in immunizations, patient survey, and incorporating that information into practice changes, a developmental screening project and then an asthma registry across the network.

At the same time, the Oregon Pediatric Society was reforming and decided to put a focus on quality improvement and so they were –

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the developers and collaborators on the developmental screening project and so we had a very engaged provider community that was learning quality improvement on the ground. And when we were able to do our environmental scan and talk to the people from Vermont about what we were doing, we actually had results that we could show to our state people and that got them very engaged very quickly. So we have a very supportive Medicaid person who's helping us out and a very supportive director of our Office of Family Health.

So we had all the pieces that we needed in terms of really having a person storm to get going. I think that in terms of the lessons learned, one of the things that I always go back to is the sequence of projects that we did in the children's health foundation really allowed for progressive teaching of QI skills to the providers. So we started with an easy project, what we thought was going to be an easy project, but it ended up being very revealing and very interesting. We picked immunizations first and I think part of the reason we did that is that we realized that every provider believed in immunizations and thought they were doing a great job but had never really looked at their data. And so while we started this project we were really teaching the providers how to do chart review and chart abstraction, which I think was a really important skill for them to learn in order to build into the other projects and rather than just look at straight immunization rates we actually broke down the reasons why people weren't being immunized because I think everybody had a misperception that the majority of people who weren't immunized were patients who were refusing vaccines or who were on some kind of crazy modified schedule.

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And it turns out that the majority were actually just missing their check-ups and so we needed to actually work on recall systems and getting people in for their preventative service visits rather than lecturing parents about the benefits of immunizations.

So every practice was able to take their own individual data and decide what they were going to do with it, to move their immunization rates forward. For our entire network, again, of 110 people in two years we moved our immunization rate up about six percent, which for as many kids as we were seeing was I think pretty significant.

From there, again with the Oregon Pediatric Society, we decided to work on developmental screening and what we found fairly early on is that the value of partnerships is really in the conversation. We pulled, for the first time, providers and early intervention people together into a room to talk about why providers weren't referring to early intervention and why early intervention never talked back to the providers, which is why they weren't referring in the first place. And so it was this sort of weird loop of misinformation and it turns out it was as simple as a consent to release information. Once we got over that barrier we were able to go out and start training providers on how to do developmental screening and within the first quarter after we did training our county EI referral rates went up by 58 percent, just in the first three months.

Really, it was about sitting down and having the conversations with the different sectors and figuring out where the barriers were

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because the problems are common I think across the sectors and sometimes the solutions are easier than you think. But until you actually sit down with the different people who are involved you don't know either of those two things, I think.

So last July we had the opportunity through some support from the director of the Child and Adolescent Health Measurement Initiative and the Department Chair for Pediatrics for Oregon Health and Sciences University to start our improvement partnership we got some in-kind support CAHMI and some financial support from our university and within a couple months actually had a couple of big contracts land in our laps, which I think were projects that spoke to the natural relationships that needed to be built across sectors. The first one – well we're working on CHIPRA, which I think a lot of people are familiar with, but the ABCD3 grant is another one that I think is by its very nature collaborative.

The ABCD3 project really focuses on that communication loop between early intervention and the primary care providers, and so by nature you have to have those people in the room. You have to have public health and visiting nursing in the room. All those kind of people who would be involved in screening and care coordination across sectors. So it's a great place for a project like ABCD3 to live, is inside an improvement partnership.

So that's where we are. So I guess we open it up to questions.

Female: [INAUDIBLE] few more ****.

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JUDITH SHAW: Just a few more thoughts and then I think we can open it up for a discussion and questions about how we get started, how you might get started, where you're at in your state. I have the same story that RJ has, as far as the well-child care rates. Why did we do systems improvement? Why is it important to come together?

The Health Department look at poor preventive services outcomes in Vermont. We had low preventive services in certain areas and one of the practices that had low rates said, "You know, we'll just educate. We'll do some more education around immunizations. We'll look at our storage. We'll look at this and that," but vCHIP came in and took a look at what was going on and worked with the practice and we've found the same thing. That well-child **** rates were low. And so what happened was very interesting.

Connie, front desk medical assistant at one of the collaboratives, said, "I got an idea. What if I put aside all the acute care charts at the end of the – put them aside all the acute care charts and at the end of the day look at the kids that are overdue for well-child care." Now again if you have any MR that can run these numbers for you, you don't need a Connie. But they didn't have that. So Connie came up with this idea. So what did vCHIP say to her? "Okay, Connie. That's great, but take a week and write down the number of children that you identified that were overdue."

So 30 percent; she collected the data, we helped her come up with a little form where she could check it off; 30 percent of the kids were overdue for a visit. So every day Connie takes the charts and

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calls the patients. Then what do I say to her? Go out a month and re-look at the kids that you've scheduled, or six weeks, for a week and tell us how many of those children actually kept their appointments. Seventy percent. So Connie can go back to her medical director with some data to justify the half hour at the end of the day that she pulls the charts and identifies the kids. So what's behind the story?

It wasn't the medical director that came up with the solution, it wasn't the nurse. It was Connie. And this practice says she's much happier, the staff are much happier, they have solutions when there's a problem. The Health Department's happier because it raised all the boats. It gets the kids in for their well-child care.

So then one day, the end of the story is I'm sitting in my office one day and the phone rings and it's like, "Is this Judy Shaw, like the director of vCHIP?" And I'm like, "Yeah," she goes, "This is Connie calling from X Practice. We noticed your son was in yesterday for an acute care visit and he's overdue for his well-child care check." I'm like, "I knew that I was supposed to make that appointment, I just haven't had a chance." And Connie's like, "Well, it's working isn't it?"

So there's an example. I mean, it's just – it's an amazing thing and sometimes it's not rocket science but it's what it takes to get solutions into the practice and I think that's the message that we want to impart today. The other message through all of this is listen to the arm-in-arm. Listen to the groups that they spoke about. If Karen Hughes was here today, she's the Title V director

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from Ohio, she came up to me at the 75th anniversary for Title V last Fall and she said for the first time we went in to a budget hearing and the people at the budget hearing said this has never happened before. She went in, Title V, so MCH, the Health Department, Medicaid, the AAP chapter, the researchers from Cincinnati Children's, all of them went in together with the same message, the same ask together and the budget hearing people said, "We've never had anyone come in that's all aligned. We have the AAP advocate, we have the health department advocate, we have Medicaid, we have the clinicians, we have academia, the university." But this is the first time – and think about what's it going to take in children's health care if we're not all on the same page and we're not all sending the same message within our state about the child health priorities.

The last piece is how do we decide what to do. How did we come up with these projects? Do I just pull them out of thin air? No. I sit down with Breana and her staff and I said, "What are your priorities for the next year?" And then I look at the faculty at the university and then I talk to the clinicians and we come up with a plan together based on what is feasible, what we have funding to do, what the priorities are, and we work on work plan and that's what we put forth.

So it's not just up to me, it's not just up to Breana, it's not just up to the clinicians, but we really work on the work plan together. So those are some of the take-home points. So now I want to open it up for questions and I worry about the video because I know

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you're – but what if we come out and sit and talk to people? Is that
going to be a problem?

Female: [INAUDIBLE] come sit up front ****.

JUDITH SHAW: Yeah, 'cause they don't have microphones. Will this pick them up?
I'll become Oprah? Oh, okay.

[OFF CAMERA CONVERSATION]

[AUDIO INAUDIBLE]

Female: Kansas. Yes, I'm a Region 7 Project Officer for home visiting.

Female: I'm from Georgia.

Female: I'm the Medical Director for MCH programs.

Male: I'm with the Maternal and Child Health Bureau **** home visit program.

Sue: I'm Sue Robertson with **** Home Health Care ****.

Sue: I'm Sue Lynn with the Maternal and Child Health Bureau.

Chris: Hi. Chris Degraw from the Maternal and Child Health Bureau Bright Futures.

Patricia: Hi. Patricia Hashima. I'm not an epidemiologist but I'm from CDC.

Female: Hi. I'm also with HRSA, Maternal and Child Health Bureau in Region 8.

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Female: [INAUDIBLE] The other thing that was fun about when you're a provider, 10 years ago **** at the university that want to come to **** talk to you about something at lunch.

Female: Well, okay. But not another **** pediatrician telling me how to do my job. You know that feeling when you're in the practices that **** and I feel this way sometimes about national guidelines too. You know, you get the Bright Futures AAP, which an amazing document but it's a lot to do with your well visits. So the reality **** I don't know if I need this today but when these teens come down or when the faculty comes down they really have the right to be here **** is what you're doing is great, is there anything we can do help you. **** very low key and I think what I love about the ten years is now we're in health care reform central in Vermont and there's a lot of legislative mandates about what you should be doing and **** deliver care and I think that vCHIP is another bridge softening ****, "Yes, it's really important **** quality care **** cost effective, but let's just work on the relationships we already have."

The humor part of it is that they brought sandwiches. If you're going to do this it has to be a choice and so **** the piece of adolescent health project was to say if we look at risk behavior **** teens, we want to do [INAUDIBLE] sexual health, would you like to talk about ****. And then the providers can fax back and say, "Yes, why don't you come down next Thursday, bring a sandwich and we'll talk about teen safe driving." Instead of [INAUDIBLE].

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And I also love what **** meant to say **** now is just the whole **** [INAUDIBLE] loves a system change because they're frustrated. They feel that constant **** of **** doing their job. So we had a lot of the change that came in our practice came through office manager and their ability to learn about the chart pulling and the chart review and then when you have external home chart reviews. This is another phenomenon in practice that I thought ****.

You know when private insurers do chart reviews, there's always that sense as a practitioner if you're not looking in the right place ****. You know, when they tell me that only two percent of the **** that is false. So the learning of the process of where it is in the chart and ****. That also **** very thoughtfully by vCHIP and very collaboratively instead of ****.

[INAUDIBLE]

R.J. GILLESPIE: The entire office staff as well. And it was pretty clear even in our first training that the providers had no idea what the medical assistants and nurses were doing during their day and vice versa. And so when it comes to doing a practice change, you really have to make sure that you have the entire team there in order to make the change effective and sustainable. The other thing that jumped to mind is we have one of our – the ASQ was actually developed in Oregon at the University of Oregon and so we had a provider in Eugene who's very instrumental in getting some of the early tests of screening done in practices and he always said that it's all well

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in good for the AAP to say, “Thou shalt screen, but somebody’s got to bring the bagels.” That you really – providers want to change and they want to do a better job but they often times don’t know how and unless you provide them with a program where it’s really soup to nuts. Here’s how you do the screening, here’s who you’re going to refer to, and here’s how you actually make that change happen in your practice, which is what we did with our development screening training. We included all of those pieces so that the change was safe for them and it was easy for them. And also I think the messaging, in terms of it was provider to provider for us and so I could go in there and say, “I did this and it wasn’t so bad.”

Female: [INAUDIBLE] I’m a wannabe as well and so want to get a sense of ***** been or how have you – has there been funding for start-up or how has some of that occurred because I think that that’s a barrier. I don’t think it’s insurmountable but I think it’s usually sometimes it doesn’t take much but that sometimes the ***** . So that’s one question about kind of from funding structure how that’s worked. And then also thinking about has – and it sounds like all of the states have had their Medicaid and private insurers as part of it – have incentives for quality improvement been included as part of the work incorporating those. I know in our state, and I don’t know what it will look, we have a new Medicaid director but there’s been paid for performance or whatever you want, so have there been alignment of that.

And then my third, this is a lot of questions, third thing was there’s a lot of quality improvement initiatives in organizations in this

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state. Some focused pretty much only on adult, but wondering about how you've tried to bridge that and connect that so that it's kind of a cohesive way of looking at quality improvement and health care delivery. And I'll stop.

Female: I can take the first one as far as funding goes. We did have funding from Commonwealth Fund to spread it to five states and then those were so successful **** funding for another five. That's gone away. We do have fund -- \$10,000 per state. It was very small, but what the states told us is it gave them the impetus to be able to say to people, "You've got to come; we've got funding."

Now under CHIPRA, we added a category E under CHIPRA that is to sustain the improvement partnership and NIPIN networks. So it affords us the opportunity to do the conference calls, to hold the annual meeting and to do some work under CHIPRA. And albeit it's not a ton of money, but it at least gives us funding to support the next four years. It doesn't give you funding but the thought is is if you join and get involved in NIPIN at least you can say you're part of that. As far as funding the sites, the NIPIN sites would love to do a joint project so that we're all collecting -- we're all working on quality improvement maybe around immunizations but collecting common measures.

And we are looking for possible sources of funding. Chris and I had a conversation yesterday about that, whether we go to a private foundation, Kellogg, RWJ. Kellogg just funded Help Me Grow to disseminate the Help Me Grow model. So that's a possibility. CMMI Medicaid Innovation, see if they're interested. Again, this

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would be to support states. This is not to support me. This is money – if I said if somebody wanted to give me a lot of money, I wouldn't take it. I would get distributed among the states so you can build up that local expertise.

As far as the pay-for-performance, we do have the NCQ we have a blueprint **** Vermont so the practices, the ped – it's been adult, pediatric practices will get an enhanced payment, but I don't know about pay-for-performance [INAUDIBLE]

Male: Yeah, I mean there is some pay-for-performance but the specifics about how we did it, we used the \$10,000 to say if we got these people to sign up they'd come to the table and talk about it and then we specifically wrote it in. We had a children with special healthcare needs grant so our child development surveillance in autism was written into that. So we used that funding and we didn't completely finish it so actually we had an autism grant, which went to long with us. So we used that to finish it and then looking at CDC we had an CDC asthma grant and written into that we – one of our projects was a quality improvement of asthma care in school-based health centers. So we used – the wannabe is to get the money they got and then get staff that actually could get the money and not – I'm not there yet and the plus we have a new health commissioner who's particularly interested in effectiveness kind of thing. We have the Medicaid where you're supposed to do things more – less money and improve things so maybe there's some possibilities, but I've had conversations with our School of Public Health, with the Department of Pediatrics because they go – so in some ways trying

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to get people to put some dollars on the table to start it and I'm still not there, so.

Male: Because of the way we started our quality improvement projects through the independent of practice association, we did actually link not some pay-for-performance but pay-for-reporting incentives into our immunization initiative. There was a big fear on the part of the providers that they were going to get dinged for bad immunization rates so they didn't want to report their – or be graded on their rates so to speak and so it was a easier pill to swallow to do a pay-for-reporting mechanism. We did, through some other funding sources, pay to get the first bunch of people into the development screening project until we could kind of get the word of mouth going around. And then the other big incentive I think for providers is the maintenance and certification hook, which we've actually linked most of our projects to maintenance and certification.

So we've got – I guess we've had four projects in our state so far. And that tends to be a bigger hook than the financial ones by a long shot because I think that people are just starting to get into the panic stages of maintenance and certification so I think that's a big hook, yeah.

[INAUDIBLE]

Female: In our state, I think the child health piece of that I think vCHIP – we were lucky because we already had our trusted child health improvement gang. So when I – you would know the acronyms better but there are

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plenty of other entities but pediatricians they feel sort of corporate and over there and we have this trust – this is why the AAP piece of this partnership is so crucial because there's such trust. This is actually people we know and that we know that concept in practice **** where do you get your information. It's from a trusted expert. It's not from journals or you know they do those studies about where the pediatricians learn how they should be doing things. And it's always from another **** trust.

Female: ****.

Female: Yeah and I think there are a lot of other quality efforts in the state and I made a conscious decision – I've been advisory group that advises me and if any of you are thinking of starting this, I would strongly recommend getting a core group of advisers. They're not a bore; they don't tell me what to do, but they advise. And there was a point in time when people tried to get vCHIP to focus on some adult projects. And we made a conscious decision to stay focused on kids and I think that's an important lesson because it was one state that was one our earlier states, got the improvement partnership up and going, adult was working on quality so they merged with a adult, kids fell away. It's a critical, critical point. So my sense is –

Female: [INAUDIBLE]

Female: Yeah.

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Female: [INAUDIBLE] going for seven, eight years in Vermont to look at adult *****. I mean, we're doing just fine with it but it's that constant reminder that we're not going to look at the chronic care. They have a nutritionist on the team who is really good with adults with diabetes; it's not going to help our patients with special health needs. ***** but it's not tension anymore, it's just dialogue. But I am interested in his expert phenomenon because the UVM faculty that work with vCHIP are already known to ***** state for their work *****. So it has this sort of wrap around.

[INAUDIBLE]

Male: We're good? All right.

[INAUDIBLE]

Male: The other observations I would add to the disKusion is particularly for states that are considering trying to make this happen is I would not underestimate sort of the value of they're just sort of being one seed issue to sort of get you started. So in part, there's a bit of a chicken and egg question but if there's sort of one area that the provider community, the pediatrician community, and the state albeit the health folks, the Medicaid folks, the insurance folks, if they share an interest in any one thing. Typically states actually have opportunities for grants, even in this day and age of shrinking budgets, but states also sort of increasingly are lacking the bandwidth and resources to run with. If you can get a core group of individuals who can say, "Alright, we're going to focus on name the issue." Development screening or asthma or whatever, it just

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gives folks something to start with because the idea that you add water and have an instant improvement partnership it doesn't work that way. They grow from small to medium and large and frequently it's that first issue that sort of helps build knowledge, experience, and infrastructure that you can then sort of build upon. So I do think it's really – so it's not like – because if you just say, “Well, how are we going to get everyone together and get like a robust improvement ***** partnership?” You can't really go from zero to 60 in that fast. You really have to figure out how do you get started and I think Judy has this opportunity through NIPIN and CHIPRA to do some road trips, technical assistance, site visits, mentoring to get folks up, but locally there needs to be one or two folks who want to get something done around some health issues.

And the other thing I would add, changing channels slightly, is there is an increasing focus I think for practitioners to be doing quality improvement and the opportunity certainly exists for a pediatrician or family doc to just do an individual, independent quality improvement thing in her or his office and that's a good thing. But if –

[INAUDIBLE]

Female: [INAUDIBLE]

Male: Right. It's a good thing but it's not going to move the bar in terms of improving care delivery and outcomes for kids in your state. And I think what differentiates improvement partnerships is a partnership *****. The fact that beyond the frontline providers there is some

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active collaboration with other folks who have skin in the game for kids health. So it's the health folks, it's the Medicaid folks, it's the other folks and in this day and age – and families, thank you. In this day and age we're all held increasingly accountable in a transparent way to produce better outcomes with a whole lot less money. Because resources are shrinking. For Medicaid or the health folks or practices to try to do this independently is just squandering precious resources. Together you can actually really make a difference I think in the state and produce something that sort of more sustainable in terms of ongoing improvement and more than just measuring process, but actually beginning to move the bar in terms of our measurable outcomes for kids. We've all got to go there because it's a lot harder going there independently than it is trying to network. So I think networking within states is improving partnerships and networking nationally as we're all trying to do with this NIPIN network, just not enough resources to do it all on our own.

Female: [INAUDIBLE] Is that in our CHIPRA grant we do have funding for technical assistance to go to states, to teach them how to do this but one secret [INAUDIBLE] how am I going to – it really is difficult. I mean, having to hear this talk probably eight times to really – for those of you who probably heard it a few times, it's probably ****. It's hard to wrap your arms around it. The other thing is that Paula Duncan and I **** Bright Futures.

So that has worked very strategically in states to bring us in to talk about Bright Futures, to talk about preventive services and to talk about improving partnerships. So you can sell us two different

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**** to get two for the price of one because we will never come talk about improving partnerships without talking about Bright Futures. And we can actually do a special talk **** health department about Bright Futures. Talk about the toolkit **** tools and materials, all of the work ****. At the same time, we never do Bright Futures without talking about improving partnerships as a mechanism for implementing and ensuring high quality preventive services in your states.

So keep that in mind. We are putting together a readiness packet, which talks about what's worked when we do those technical assistance or site visits to states, it talks about the agenda **** together. Because the funniest story happened once. I spoke to a Medicaid medical director conference and I put up the slide with all the states and actually had a map of the United States and the Medicaid medical director **** came up to me and said, "How come Arizona's up there? I don't know about the improvement partnership, I don't know what **** Arizona." [INAUDIBLE]

And I said to him, "Do you remember that meeting last November that took place in your state that you were invited to?" He goes, "That's what that was about because I wish I had come." And I said, "Well..."

So my question to him was, "How do we get someone like you to that meeting? How does it get on your radar?" I don't think he had a good answer for that, but that concept of oh, my gosh I don't know what this is about, but again sometimes Bright Futures is the hook that will bring people to the table and I've seen that used very

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strategically in states. The editors of Bright Futures are coming to talk but at the same time we're going to talk about this concept of ****.

Keep that in the back of your mind. We can help you strategize ****.

Male: ****. The idea of doing the change, you have to have an improvement partnership team, which includes the physician. But the part about it is including a family member there really gets the docs thinking about customer satisfaction and the same kind aha experiences that happened from the administrative person happens with families. When we started, we tried to get people there and it went – we had six practices and three of them by the end had recruited a parent. It never done that before and it – you have to get over some of that, but boy that is helpful. You need that team.

Female: I noticed that we're at time and we'll stay around a little bit afterwards to answer any questions but I want to thank all of you for coming on this beautiful morning and spending your time with us and certainly feel free to follow up with us. If you could submit your evaluations as you go out the door, we would greatly appreciate it. And thank you and we're happy to talk to anyone now or in the future.

[INAUDIBLE]