

## **MCHB/EPI Atlanta GA Conference**

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### **State and National Initiatives to Improve the Quality of Healthcare for Children**

JUDITH S. SHAW: Thanks, Wanda. It's always a pleasure to come and speak at a new group, a new audience. I must admit, I've never attended this meeting before but have made a lot of new friends and seen a lot of old friends, and it's a pleasure to be here. My criteria for agreeing to speak is, one, is the topic relevant to my profession and do I have something to impart. And then second is this. I come from Vermont. And I also say what time of the year is it and is it south? So I also realize that this was an opportunity to come to warmer weather and I thank all you people from Atlanta for providing the unseasonably warm weather because right now in Vermont this is what's going on. And I've been told by my staff what I've been missing and I said no problem. So, anyway, it's a pleasure to be here.

What I will discuss with you today is improvement partnerships, a little bit about the Vermont example and why we think some of this work that we're all doing to better children's healthcare should be something to do with partnerships in general. And I'll give you the Vermont example. Then I will talk to you about a national perspective. Many of you in the room are working with us on looking at partnerships in states for children's healthcare quality. I'll talk a little bit about

that. And then look to the future and pose some questions for all of us that I hope we can engage in the discussion immediately following this and throughout the next couple of days. I will be around for the next few days for any of you who want to pick my brain or discuss anything that you've heard here.

So improvement partnerships: one model: VCHIP. Don Berwick once said to me, he's the President and CEO of the Institute for Healthcare Improvement, "What the heck is going on in Vermont?" And so I put together a presentation for him many years ago to talk about VCHIP, the Vermont Child Health Improvement Program, and what actually the heck is going on in Vermont.

So just to let you know, I came to Vermont in January of 2000 to lead what was then called the Vermont Child Health Improvement Program, a statewide initiative focused on children's healthcare quality. The name had already been decided as well as the mission. The mission is to optimize the health of Vermont children by initiating and supporting measurement-based efforts to enhance private and public child health practice. Well, a lot of what we're talking about here is that partnership, public/private partnership and the use of measures.

And I landed in my office and I said, "Oh, my god. What the heck am I doing here? I just moved up from Boston, Massachusetts, and now they want me to solve the quality problems for children's health in an entire state." And it was a pretty daunting task to try to figure out how to do this. And what I want to talk to

you about today is the path that we took towards that and what was sort of the essentials elements of it that I think this audience in particular might be very interested in, and then talk about the future.

In Vermont we partner basically with anyone who has anything to do with kids or has any interest in children's healthcare, whether it be the Department of Health, the academicians at the University of Vermont, the American Academy of Pediatrics, their chapter, the American Academy of Family Physicians, the managed care organizations, the regulatory organizations, Medicaid, anyone that really has anything to do with children and children's healthcare.

This is the timeline. When I went to speak in Ohio just recently, and I know Karen Hughes is here, the Director or Commissioner of Health came up to me afterwards and said, "This was the single most important slide that you had in your data set," so I'll spend a couple minutes of this talking about this and to tell you the story behind this. Basically, back in the 1990s Vermont decided to work on a periodicity schedule for children for Medicaid. And I don't have a lot of time to go into it, but they came up with an agreed-upon set of preventive services, the periodicity schedule for all kids in Medicaid, and said, "Well, why not all children? Why is this just Medicaid?" So they decided that this would be the periodicity schedule obviously adapted from the American Academy of Pediatrics and other guidelines for all children in the state. But just because they decided on

what those guidelines are and those standards doesn't mean that that's what happens. And Wanda just showed you earlier the variation in healthcare.

So at that point Vermont said, "Well, we know what we want to do and what we aspire to do. How do we know we're doing it?" And at that time that's when VCHIP was born--and I don't have time to go into the story about VCHIP but if people are interested in it I certainly can tell you that--and I landed on the scene. And at that point we decided that we wanted to take a look at what do the guidelines say in the state and how are we doing relative to those? And we had some seed funding and, actually from NICHQ Doris is here to talk to you about, to work on preventive services and to work with pediatric practices to look at how they're doing vis a vis the guidelines and help them to do a better job in their practice of improving the care they delivered. As you can see, that was around 2000.

What happened is we quickly--everyone in the state, every pediatric practice except one, signed up to participate. Now, we only have about, now currently, 39 practices in the state. I mean, you could find that many in a block in New York City, but it was the entire state of pediatricians working on quality improvement. As we began to work with them, the family physicians came to us and said, "We do--we want to learn how to do quality improvement. We do preventive services. Can you teach us to do the same thing?" The hospitals came to us in the newborn period and said, "You know what? We want to make sure we're doing

the same thing the pediatricians are doing. Can you come in and measure how we're doing and help us to think about our systems of improvement?" Then the obstetricians came to us and said, "We're very interested at looking at prenatal care and using a systems approach to thinking about improving care during the prenatal period." That's when we applied to the March of Dimes National for a national grant and were awarded that and developed the Improving Prenatal Care Toolkit, which is available on the VCHIP website. And Milt Cuddlechock was very involved in that, in the development of that.

Then we're working with youth and foster care. The managed care organizations came to us and wanted to do a project on youth. So what I want you to see is this expansion of "if you build it, they will come". Basically, we've become the go-to in the state for working on quality issues. We do some research. We do some evaluation as well. We're based at the University of Vermont, but, really, are the think tank that works collaboratively in the state to think about what the data shows, how to translate that knowledge into action, and how, really, as Janet was talking about earlier this morning, how to be the translation arm for what the research shows, what the evidence shows, into practice and be the practical arm for implementation at the practice level.

And finally, in 2005 many of you in this room had called me to ask me to come talk in your state or teach your state or share how we did this in Vermont. And I was getting so many phone calls, yet I wasn't paid for it. And the Commonwealth

Fund in New York came up with some funding to fund us to teach other states how to do this and that's what I'm going to end with in talking today.

Just going to focus on two of the projects to give you some sense of what we did and the data and the results. So the Preventive Services Initiative; like I said, we worked with the data reports on 31 of the 35 practices in the state. They serve over 80 percent of the children. And we focused on the following preventive services for two years old--I'm not going to read them; you can see them--and then for four year olds, looking at how practices were doing, viz a vis the guidelines and helping them to think about improvement.

What did we find? This is a pre-post design. Eighteen months later the practices did audit monthly their charts, and I don't have time to go into the details of what we did but we worked very closely with the practices, coaching them on improvement, and we used the collaborative methodology, the breakthrough series collaborative methodology, bringing practices together, and then coaching them, providing the tools, the materials, and the methods for how to do is. And, again, Janet talked about the research translation and the need for tools and materials.

So we found that we had improvement in many of the areas, but we didn't stop here. And I think this is the take-home point. If you see the improvement, the P values, okay, what explained the improvement? What accounted for this

difference? So we took a look and the left side of the graph is those who chose one of those particular areas as a goal and focused on it particularly in the coaching and the improvement and those who didn't. The bottom line is vericella, environmental tobacco smoke, risk assessment, lead screening, back to sleep, t.b., and vision, just so you know. And almost all the improvement could be explained by those who focused on it. So what does this tell us? Just producing a guideline or a recommendation or data doesn't translate into change in the practice level. Practices really need the tools, materials, strategy, and coaching to go along with it.

I'll tell you one other story. Our youth project; we were working with practices in the state on youth health improvement. The managed care plans came to us and said their well childcare rates were very low, their HEDIS measures were low, and they wanted to work on improving it. So we did a broad youth improvement initiative looking at substance abuse, looking at strengths, looking at youth development, not specifically looking at getting the rates of well childcare up, but a broad statewide initiative. And about three or four years later the rates had gone up. Blue Cross Blue Shield took a look and the rates had gone up substantially. And so one very smart person in Blue Cross Blue Shield went back and stratified it by those who'd participated in the VCHIP project and those who hadn't and it could almost all be explained by the participation in the VCHIP project. We're redoing that data for Medicaid right at the moment. It took us about a year to get the data and get agreement to do that. So we'll let you know to see

if that holds true for the Medicaid population. But the take-home point is all of the data, all of the information, is only so good. We need to help translate that into the practice on how to do improvement and we need to provide them with the tools and materials.

Like I said, as we started working with the pediatricians and the practices, the hospitals came and said, "We want to do the same thing. Can you help us to get better?" So we worked with all 12 hospitals. All 12 hospitals signed up. We did baseline and follow-up chart audits and they did their same thing, the PDSA cycles. We coached them. We had face to face meetings.

Here's some of the data that I thought you might be interested in, and I don't know if you can see it, but I highlighted in yellow some of the areas. Hepatitis B: Assessment of Maternal Status went from 66 to 87 percent, and that was a 21 percent increase. Breastfeeding: the Assessment of Adequacy improved by 24 percent. Hearing screening performed went up by 21 percent. Sleep position assessment went up by 43 percent. And smoke exposure counseling went up by 29 percent. And this is just working with the newborn--with the hospitals to look at their system of care, what tools and materials, and try to be consistent in how they approach this work.

So like I said earlier, right now we've got 85 percent of the pediatric practices, 23 of family, 27 of O.B., 39 of the certified nurse midwives, and 100 percent of the

Vermont hospitals all trained in quality improvement, all working on quality improvement activities. So now basically all we have to do is dump in new topic areas and new tools and materials. We've really brought them up to speed on systems improvement and how to do that in their office. So we look and work very collaboratively with the Department of Health and with Medicaid to look at what the data shows and to think about initiatives for improvement.

So because we're focusing both on prenatal, newborn, pediatric primary care, and youth, we like to say we have the MCH continuum. And I must admit, I didn't make the slide for this group--I made this about five years ago to demonstrate even preconceptional health, that working with the youth population we feel is an opportunity to really think all the way back to preconception as well.

So the next piece is national perspectives on improvement partnerships. And I told you that what we were doing in Vermont, the timeline, we've really become the go-to. We're a collaborative organization with everyone in the state. And now we're trying to help other states and collaborate with other states to think about this as well.

What's an improvement partnership? Like I said, I got funded to do this and as I began to talk to other states, realized we really needed a definition. Very similar to VCHIP: Durable regional collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve the quality of

children's healthcare. Again, the collaborating organizations or really anyone in the state with interests in children's healthcare improvement.

Why is this important? Why is a regional approach to quality improvement so important? We believe that improvement requires action at multiple levels of the system. It's not just the doctors' problems. It's not just the parents' problems. It's not just your problem as Title V or public health workforce. It's not the managed care organizations' problems. It's all of ours. And it's when all those levels collaborate and work together and think about the system is really when we're going to have an effective healthcare delivery system.

The credo that all improvement is local. I may come to some of the states and talk about quality improvement and about the VCHIP model, but what I want to do is go away and never have to come back. And have that state develop the capacity or that particular region develop the capacity to do this work. And I also want partners. I want to be able to share across states our strategies, our tools, our materials, what we're doing. Don Berwick contends there's enough money in the healthcare system; it's just not used wisely. I contend a lot of the--I would say we have the knowledge out there, the tools, the materials, and the strategies; we're just not very good at sharing it. We're really good at recreating the wheel and duplicating efforts. And how many people have used the VCHIP toolkit that has all the measures for prenatal care all documented and all the systems improvement strategies, probably don't even know it's out there. How do we

share and learn from each other? And I think that's important. And then state and regional efforts for healthcare for children are innovative and still successful but not connected and broadly disseminated. So, again, we've got to do a better job of sharing what we're doing and learning from each other.

So improvement partnerships. Here's four examples of improvement partnerships around the country--I'll talk about it a little bit more--and their logos. VCHIP, Envision New Mexico, UPIQ--and Nan Streeter's here from Utah. When I got the pleasure of going to Utah--I like UPIQ because the acronym is the Utah Partnership to Improve Child Healthcare Quality. The idea is you pick what you want to do and we'll help you fix it, which is really the heart and soul. And when you're talking about pediatric practitioners and practice, they're willing and interested in improving the care they deliver. They don't have the tools, materials, strategies, nor do they have the data, the measures. So, again, that idea of "you tell us what you want to do and we'll help you, but together we need to come to that conclusion." And West Virginia is a new group that we just began working with and they just came up with a logo and a name. And they just started about six months ago. So here's the improvement partnerships. If your state's on this map in color I would suggest that you talk to me afterwards if you have no idea what this is about. I'm happy to talk to you a little bit about what's going on in your state.

The existing sites, Vermont, New Mexico, and Utah were the founding states that we call improvement partnerships. We worked with the first round of states, Arizona, New York, Rhode Island, Washington, and Washington D.C. and now we're working with the second round of states. We finished with that first round last year. And all of these states are making great strides. I just got an email from Washington State that said, "Thank you. It wouldn't have been possible without your support." They have the Washington State Collaborative to improve health focused on adult care and they just got Medicaid to allocate funding for the whole child piece of work--they've been working just in the King County area--to go statewide with quality improvement on asthma, medical home, and overweight prevention. So, again, huge success.

Karen Hughes just told me about some good news in Ohio as far as getting funding. West Virginia's got three medical schools; they got their medical schools to collaborate on the West Virginia Improvement Partnerships. So states are starting to look at collaborations between academia, the practicing community, professional organizations, public health, Medicaid, the delivery system, in improving children's health.

So the unique features of an improvement partnership can be the focus for research so they bring in the academic piece so they can help publish. They can redirect faculty researchers to local improvement efforts. I like to say I took the people from the University of Vermont and focused them locally and help do local

work. They can improve policy through published reports and testifying. We certainly help with that. They're viewed as a solution to problems and an honest broker. They're often joined leadership, or a leader has a joint appointment between academia and state government. And the advisory group focuses on strategy and implementation, our advisory group to VCHIP.

A look to the future. So Lisa Simpson in 2004 called for knowledge brokers to be champions and she said, "Between researchers and those providing care, suggesting the federal government has a responsibility to support child health improvement and it should build on the improvement partnership model established in states to bring together agencies, private payers, and provider communities." This year, Dr. Livingood published in the American Journal of Public Health, "The academic agency partnerships can address increasing demands on public health systems with sparse resources." As the editor of Bright Futures, my question for you, as we look to the future, is are you ready? We've got an agreed-upon single set of guidelines for children's healthcare. How do we get bright futures and the standard of care for children in the country off the shelf, into the hands of the practicing pediatricians, family physicians, nurse practitioners, and into the parents' hands? The National Business Group on Health just came out with Investing and Maternal Child Health and Employees Toolkit, the business case for MCH. Although it's for employers, I think there's elements in that that we all can use to build the case for MCH improvement in our state.

And I want to thank you for your time today.