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

DORIS HANNA: Thanks. Like Judy said, I'm thrilled to be here today to present to you today about our work at NICHQ, National Initiative for Children's Healthcare Quality, and I send, you know, a welcome and greetings from our CEO, Charlie Homer. As Wanda said, he had a previous commitment, but I'm thrilled to, again, step in and answer any questions you have about our work.

And I'm hoping, as I was listening to Judy's presentation, of course, we spend some time on the phone together, I'm so impressed with the themes that will emerge about the importance, number one, of children's healthcare quality and really moving this agenda, as well as the notion of partnerships, getting what we know as evidence into care practices, and then ultimately to the families and children that we're here to serve.

The other thing that--I just came in, actually, from a meeting in Orlando from the Institute for Healthcare Improvement, Don Berwick's work, and one of the things that really came through in that meeting was the importance that Judy alluded to about this notion of all improvement is local and we really are just at the beginning edge of understanding, if you will, the context of care, you know, and

the complexity of the systems that we're working with. And it is no small task to take an evidence-based practice and guideline and actually make it come alive in, again, the work of the practice. And we're learning more and more about, again, what a huge challenge this is. So, again, I thank you for the invitation to be here and for Wanda bringing quality improvement to this audience.

So I want to begin by telling you just a little bit about NICHQ. Again, the origin's very similar in time, you'll probably notice, to VCHIP. We were founded in 1999 and our mission is to eliminate the gap between what is and what can be for healthcare for all children. And we consider ourselves an action-oriented organization and it's dedicated exclusively to improving the quality of care for children. And we consider ourselves also a national resource for healthcare improvement organizations, foundations, clinicians, families certainly, government agencies, that often we will serve as a clearinghouse, if you will. If people have a concern or question they'll call us up and we're very much in the resource mode. And we are a national organization. Our home office is in Cambridge. Fortunately, we share space in this big open concept with the Institute for Healthcare Improvement. So we're sort of always, you know, in the think tank of that work. And we have a national cadre of key advisors and we have a very geographically distributed staff.

So what we do, our CEO, Charlie Homer, laid out three words that do a good job of describing our work. We innovate. And we demonstrate. And we accelerate

adoption. And the innovation piece is something I'll talk a little bit more in terms of the learning collaborative model where we see ourselves very much, again, on the front end of thinking about what are the good ideas. What are the ideas that are ready for use? And hopefully I've provided one example of something that came out of our recent work to really make improvements in good care. It's not just about knowing the evidence but it's finding out the good ideas that are going to help clinicians implement that and really imbed it in the work they do. We talk about hard-wiring the system so that if one person left the system would function this way reliably and perfectly; it's not one person dependent.

Then we demonstrate target initiatives that show the feasibility part of making improvements. Like, you really can do this. And if, you know, we have a good idea, we ask teams to test it out, and then we can come away and feel confident that it works in that one setting. Of course, we need to check it in others but it is a feasible approach.

And then, finally, this notion of accelerating adoption, which really much goes to what Judy spoke about in the work of VCHIP is that building this national, or in her case this statewide, infrastructure to make a durable renewable resource to make sure that this adoption occurs.

So we have--one of our tenets, you know, we always talk about the model for improvement and the very first thing is: what are we trying to accomplish? And so

Charlie Homer several years ago at our annual forum laid out what he considered a bold agenda for pediatric healthcare like looking at, you know, all the areas for improvement. Where should we really focus and target our energy? So he named: Preventing Childhood Obesity, and, you know, we're taking that on from the perspective of, you know, our first job really is to enable the healthcare community to do what they should do, their piece of this emerging epidemic. So we're really trying to focus on the provider community and give them the resources and tools they need. Focus on youth with special healthcare needs. We have a theme related to purging harm from children's healthcare. And then, finally, promoting equity in care. And I was thrilled to see Wanda mention the disparities in her opening comments.

And our services are essentially training and transforming care, learning collaboratives. We also spend a lot of time talking about and creating and sustaining improvement resources, again, these renewable sources, and setting the national agenda for change.

I just want to highlight, you know, to elaborate a little bit more about some of Judy's comments and how many resources we have, and thinking about this from the place of abundance in terms of how much money is already in the American healthcare system. And we spend a whole lot of time talking about constraints on resources but, really, we have a lot of resources; we just don't call on them. And so these are some example of resources, you know, that exist in

states that, again, we're learning more and more about the importance of partnership and building on these existing resources. So, certainly we have the professional society and the medical association chapters; departments of health; Medicaid agencies; the academic medical centers have been phenomenal partners in this work; state and local non-profit groups; and of course a variety of combinations of these groups.

So I want to just give you a quick overview of--we've mentioned this notion of a breakthrough series several times. So I'm curious; how many of you have heard of this? Let me see. Okay. Just a couple. Good. So this was developed, actually, at the Institute for Healthcare Improvement in 1995. And these are some sort of key elements; again, the more we do these breakthrough series collaboratives, they sort of take on, you know, different characteristics, but these are basically the themes. So it's a quality improvement method that's designed to refine and spread improvement ideas throughout a system. And typically what happens in a learning collaborative is you get a group of key stakeholders working together to make improvements in a very focused area with a particular aim. So it's sort of setting it up so that everybody is focused on one aim and we're all working together as part of a team. And we've learned in NICHQ the importance of doing this and really sort of setting it up almost from the family's perspective, like the family expects our system of care to exist in a particular way to provide a care service continuum. And so we've tried to set it up and think about as the family experiences care who should we have as the stakeholders at the table. We

obviously bring in subject matter experts, application experts, frontline staff, always a parent as a member of the improvement team. And we use data to support improvement.

So here's an example. We had a medical home learning collaborative. And our aim was to improve care for children with special healthcare needs by implementing the medical home concept. And we also wanted to foster the relationships in this partnership idea between Title V programs, their state's primary care community, and enable Title V to continue to support the improvements and spread the improvements through their state. And this was our idea that we try to integrate and embed four key concepts. One has to do with the notion of medical home, the learning collaborative model, teaching the model for improvement, and what we call now the model and framework for spread. And then we also have very capable, of course, regional, state, and local resources in Title V.

And so here's the results that came out of the Medical Home Learning Collaborative. And, again, I can hope you can appreciate, you know, again, the theme here that you saw on Judy's slides that when teams work together in a particular focused area you really can make substantial improvement. And this is using the Medical Home Index which is available from the Center for Medical Home Improvement and the domains on the X axis represent organizational capacity, chronic condition management, care coordination, number four is

community outreach, data management, and then finally quality improvement. So every dimension of the Medical Home Index improved using this methodology.

Here's another example. We had such good luck with our first round of Medical Home Improvement we had a second one. In this we focused a little bit more on the outcome measure. And outcome measure was emergency room visits. And you can see the substantial reduction in emergency room visits.

So now we're ready to go beyond the medical home and move more toward, you know, again, looking at the vertical coordination between secondary and specialty care, tertiary care, as well as the horizontal coordination between community and public health. And these are some results that we've had from a recent learning collaborative about newborn hearing screening. As many of you probably know, we do a great job in the United States screening newborns for hearing loss. It's, depending on what state you're in, it's about 95 percent nationwide about newborn hearing screening is completed. But we have a big problem nationally in delays in care and loss to follow-up.

As many as 50 percent of the kids who fail are lost to follow-up at the end of the first year of life. So MCHB funded NICHQ to do a learning collaborative and see if we could get our arms around some good ideas that we might test. And we have two things that are coming out of this work. And, again, it seems so elementary, but our teams discovered that before the baby is discharged you

clearly identify the pediatrician and/or family practice person or nurse practitioner who's going to be accepting the care of the baby and verify that before they leave the hospital, because often they're written down, you know, from the newborn nursery, assigned to Team A, or whatever it is. And then mom goes to make the appointment; of course, that doctor isn't taking Medicaid or isn't accepting new patients or too far away from the family. So you verify the hand-off before the baby leaves the hospital. That was good idea number one.

And then good idea number two was often we try to--states are responsible, of course, in the Eddie programs, for following-up babies that fail. And after a week, mom's phone number is gone or the phone's disconnected. So getting two phone numbers, one of them most often was the mother's mother, the grandmother of the baby, really improved the state's capacity to hang on to these babies. And these are some of our preliminary statistics and states have been thrilled with those two--we have several other what we call high leverage changes. But those are two good ideas that really came out of this collaborative model. So I share those with you. Again, we're still developing this work and coming up with a list of good ideas.

So from NICHQ's perspective we're in this next step of building systems of care and thinking a little bit more as we work with Title V in particular about expanding our learnings for this population.

And our lessons learned are that, you know, healthcare is one part of this larger agenda that Judy laid out in terms of preventive care and knowing what really should be done for children in American today. Certainly, state-based initiatives have key advantages. We often enroll our partners in the learning collaborative by state and that really does seem to have an important effect. So anybody can be the leader. I think that's the other really important theme. It doesn't matter when you set up a partnership who's going to take the lead. It can come from a variety of sources and the point is, everyone is at the table with a common aim.

And I just want to put in a plug for our upcoming forum at the end of March. So, again, at the end we have some time for Q and A. Please feel free to ask. If you have any particular other questions, I'd be glad to answer them. Thank you.