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State and National Initiatives to Improve the Quality of Health Care for Children

Q & A

WANDA BARFIELD: We'd like to open the floor up for questions at this time. As people are coming to the microphone, just one question that I had for the panelists is, often in the state issues around quality improvement might actually be regulatory and sometimes that is helpful but sometimes it's not so helpful. And I was wondering if you could comment on how that might be incorporated in a collaborative effort or if it effective or not.

CHRISTINA BETHELL: Well right now I think it's a benefit and especially Medicaid has regulatory requirements around quality, having a quality strategy and reporting on certain aspects of quality. So leveraging that, you know, thing we need to be doing this and so let's do it and let's do it--let's measure quality in a way that meets as many of our regulatory requirements as possible. So I think it really supports the idea of bring a partnership together to have the regulations.

Of course Title V has to report on quality as well and those are often the very same issues that Medicaid either should care about or does care about. So I think the regulations are so far, I think, supportive of a partnership model of

quality and of getting it done. Without that, you know, there's not much of a stick and we want carrots but we need--I don't know, some sticks too.

JUDITH SHAW: So I'd say as we develop improvement partnerships that's part of the strategy is to look at where the--you know where there is the regulatory aspects of the reporting mandates that need to take place and can we link the work that we're doing with that and meet that requirement.

Can, if we're auditing charts--for example, we audited charts on immunization as part of our initial preventive services work and we were able to get permission from the practices to send that data to our local immunization where thereby they did not have to go in and do their CASA audit because we collected a random sample and complete data. So where can you get two for the price of one or coordinate your measurement efforts? And I think I like to look for those areas and those opportunities for helping to meet a need in a group with the work that we're doing on improvement.

WANDA BARFIELD: Are there any questions from the audience? Are there any people who are involved in these quality improvement activities because this is something that's coming. I think, you know, as a clinician it's something where there's been a lot of discussion about quality improvement and what are some of the implications, particularly with regard to disparities. And I was wondering if you

could talk a little bit more specifically about how these initiatives can be used perhaps to reduce disparities in health care?

DORIS HANNA: Let me just make one observation about the disparities issue. As everyone around this room knows, this is a very complicated topic. And one of the things that NICHQ was committed to is to look at the issue of disparities. And one of course the biggest challenges is this notion of, if you will, counting and how to counsel and coach the teams on counting in terms of parent report, what available data you have.

And so I would just, you know, I want to reiterate one point that we're learning day in and day out is the importance of from the provider's perspective taking some pain out of the system, trying to get the two for one to meet the regulatory requirements. And it's our firm belief in terms of addressing the disparities issue that, you know, if we look at the system as a whole and really try to address this up front, you know, obviously highlighting the known opportunities for improvement about disparities that the practices area faced with we--you know as we proceed in the learning collaborative, so to speak that we're trying to sort of dovetail those two particular efforts, we want to embed that as sort of part of the work that we do that of course we're addressing those disparities. It's not a, oh by the way, you know, when you finish this something else then you can take care of disparities. It's embedded in every single piece of work we do.

And I would just say for those of you that are interested in cultural competency and disparities where NICHQ has a publication available on their website that people really seem to like as a way to find their way into the issue of disparity and cultural competency for clinical care. So I'll just...

WANDA BARFIELD: There was a question I believe.

DORIS HANNA: No, there's one question over there.

NANCY TREADOR: Nancy Treador from Utah, I just wanted to make a comment. It's not related to disparities but Judy and I were talking earlier and you know I think one of the biggest challenges for quality improvement programs to either begin or to be sustained is the issue of how to fund those efforts. And I think, you know, some of the states that have been fortunate enough to have state legislators that support quality improvement efforts is wonderful--Medicaid. But obviously there are states where, you know, those things are slow in coming if at all. And you know just some thoughts I guess about other creative ways to fund quality improvement projects.

JUDITH SHAW: You want me to take that?

CHRISTINA BETHELL: Start that one, Judy.

JUDITH SHAW: You want me to get--I'll start, yeah, unless you want.

CHRISTINA BETHELL: Well I was going to say something really quick which is advocacy is important and the kind of data that I talked about can be used just to get people to pay attention. And then, you know so that it is better funded and people do understand. But in the meantime, Judy has some other comments.

JUDITH SHAW: That's the number one question I get asked is the funding of it. So what is--what are some of the strategies that people have used? The Medicaid Administrative Match clearly on any non-federal dollars that are brought into the state. We're a public institution at the University of Vermont so that we're able to draw down the federal Medicaid match if it is an activity that improves the Medicaid program.

Other strategies, private foundations--West Virginia got a quarter of a million dollars to start the West Virginia Improvement Partnership. Guess what happens when three medical schools sign a memorandum of agreement to collaborate? One provides funding, one provides staff and one provides space. So it's that leveraged opportunity.

The American Academy of Pediatrics, some chapters in--AAP chapters in your state have larger programs and staff and the capacity to write grants. Some of the other areas are redirecting resources at the--at an academician or at a

medical school towards these activities. I've been able to find and handpick people in our--on our faculty that have an interest in a particular area and get them to focus locally. Now that's not bringing dollars in, but that's certainly finding a creative way.

The external quality review organizations--Nan that actually was--and Karen, that was what funded the Washington State. I just went back and read my email. They were able to--they were rewriting their EQRO contract and they were able to set aside a piece of money for children's health care improvement as part of the statewide Washington collaborative work.

So thinking about contracting resources, looking the future the EQRO you may be able to write a piece of this quality work into the EQRO contract. Health departments, New York State--people have said to me, well that's Vermont, you can do it in Vermont but in my state I can't. New York State is actually looking at having regional quality improvement organizations in the various regions of the state that report to their larger quality improvement partnership but having local improvement partnerships. And the Department of Health is looking to fund that.

So again--and I thin the advocacy piece is critical. The more that we advocate for this as an important area, the more people will find that there is no single funding stream for this. It's going to be piecemeal for a while, but I would hope that as we're building these and those 13 states that I showed you can become a voice

for the importance of allocating funding for a coordinated effort because the work that you're doing here with data, with measurement, all the work you're doing is only so good as it getting into the hands of those who are working on improvement and those who are in the practice doing the improvement. But I think by coming together we're building a stronger and stronger case. But there is no silver bullet. There's no magic right now. It really is piecemeal in each of the states trying to creatively find funding.

But the more that we can share and learn from other--Minnesota got \$500,000 for 2008 and \$500,000 for 2009 for a medical home from the legislature. So what did they do? How did they do that? What were the strategies that they used? I think that's part of what we would like to share and learn is how to do that.

But if anybody has any ideas about the way to finance this, I'd be interested in knowing it. But right now we're all sort of pulling it together by the seat of our pants as far as financing; taking what we know about the measures and the guidelines and applying them at the practice level.

WANDA BARFIELD: Are there any other questions from the audience? I know this is a spunky group. Come on.

JUDITH SHAW: Yeah.

DEBBIE BURNSTRA: Hi, I'm Debbie Burnstra. I am from Nebraska and please take my comments as hypothetical and not necessarily related to Nebraska. These were three really fascinating presentations for me because at least my part of MCH is just very slowly making its way into the concepts of quality improvement.

But my question is kind of a follow-up on the last one and specifically about state Medicaid programs, which is how do you get the buy-in, the partnership with Medicaid when the existing Medicaid model is a very strict cost limitation and not interested in quality of care?

I know the arguments about well if you improve the quality of care it reduces your costs. But when you have a program that's specifically focused on the dollars they're spending today and yesterday it's very hard to make that. So I'm wondering if any of your programs offer resources for how to entice Medicaid into these partnerships?

CHRISTINA BETHELL: Well let me ask you a question, does Nebraska have managed care?

DEBBIE BURNSTRA: Not that I was speaking of Nebraska, but yeah.

CHRISTINA BETHELL: Okay. So any state that has managed care the Medicaid Agency is required to have a quality strategy and a public/private partnership to define what they're going to do to improve it, to build in quality related activities into their EQRO and Judy talked about the quality improvement partnerships and that kind of thing--or quality improvement projects into their EQRO to try to contract which is often a fair amount of money.

And so I think what you want to do is find out if there's not any leadership and they're not actually doing what they're supposed to be doing then that's an issue that really requires probably a higher order awareness building, if you will.

But there should be people in the Medicaid agencies that are motivated and hopefully would be open to getting some help to even think about it and to start to engage the partners that Judy's been talking about. Certainly bring the data to the table showing them how public versus private insurance, fair, you know really the whole advocacy where you're an internal advocate for quality with the Medicaid Agency being your target. I mean those are just a few ideas.

DEBBIE BURNSTRA: The internal Medicaid advocates for that have hypothetically all been laid off.

CHRISTINA BETHELL: Yeah, and the turnover issue is a big one.

JUDITH SHAW: Well I mean there's an upside and a downside of focusing on children's health. The downside is that it's a--children's health and the budget is a rounding error. But that's also the upside. So sometimes you can use that to your advantage is that in the bigger scheme of things children's health really is small chump change for many of these programs and that making the case to focus on a particular area.

The other thing is look for the carrots. And I think Christie has a really good point. In Vermont there's a rule 10 which means all managed care, including Medicaid, has to participate in three quality improvement activities a year. And our regulator said that if they participated in a VCHIP project that would count.

The other thing is the American Board of Pediatrics starting in 2010 is going to require quality improvement activities for (inaudible) recertification for pediatricians. Family physicians already have that in place. So pretty soon physicians are going to be looking to participate in a quality improvement activity that has to be certified by the board. So that may be an opportunity to build the case.

That's not going to sell your Medicaid director on how to save money. And I think that's going to be a challenge in the future is how to do the economic analysis of prevention, preventive services and is it saving money down the road. Certainly they're looking at the immediacy of their budgets and their dollars.

The other thing is, is these activities are focused on bringing together those who are delivering the care to help you as government, as state government, as Title V think about how to address these issues. And that is a strong incentive to any Medicaid director when you can get the voice of the pediatricians, nurse practitioners, health care professionals in helping to think about the system. It doesn't work in every case and believe me, I've been to states where I thought, oh my gosh, forget it, this is not going to work or in states where they've said we need to wait until the next election before we even attempt something like this.

This is not a one size fits all, but it does work in some situations. So what is-- what moves those people, what is the incentive that you could bring to them and how can you craft it? It may not work. It may not--if somebody is just a bean counter and really doesn't care about this or at least, you know, doesn't--speaks about not caring, there's probably not a lot you can do.

But I can tell you that when we recruited for the preventative services initiative and we really got every pediatrician but one in the state, it really got the eyes of a lot of people and it really opened not only the legislature's eyes, it opened the managed care organization's Medicaid to really see that people were craving this type of work. So look for the carrots as well. I mean those are a few points.

WANDA BARFIELD: I had another--is there another question?

ANITA COWDEN: A comment. Anita Cowden from Alabama Department of Public Health, Family Health Services. I had hesitated to speak on this issue because there are many people in this room who know more about this than I. But the concern expressed about Medicaid is what led me to this microphone.

Alabama has received something called a Medicaid Transformation Grant and I can't tell you a whole lot about it but I can tell you that I am very impressed with the process. The reason I as a simple data person who works behind the scenes typically got involved in the project is that my hope was that what they're doing in the future, not in the early phases, but in the future could be used for generating a public health surveillance database because we don't have a hospital discharge database in Alabama.

So I got involved and made some comments about the goals they were setting and so they've just sort of taken me in as part of their group. They have great physician involvement. I have developed an incredible respect for people who need to bring in a number of clinical care providers and get them to agree on criteria. But they're working really very hard at this and they are sold. They are highly committed to the process of improving the quality of care.

JUDITH SHAW: That's great. I have another suggestion and comment, is the learning collaborative that NICHQ is doing in the states and the work that we're

doing how many of you have ever attended any of those? Keep your eyes out for those opportunities and see if you can get a day off or half a day off to go and watch and understand what takes place when we bring practices together to think about quality improvement. You too are the messengers. It's not a top down, it's also a bottom up. And if you start to talk about the importance of the data that you're collecting and how it can impact and be beneficial to the learning collaboratives and the improvement activities taken on in your states that's going to be important as well.

The other way to get at this is to get Medicaid directors, commissioners at the highest level to start to share and learn what's going on in their state. And we're starting to do that in New England, bringing together the Medicaid commissioners to talk about the importance of quality improvement. And there's one state in New England, and I won't say which one it is that it's really not on their radar screen, it's just about the finances. But you know, there's other people in that state that are willing to look more broadly. Get that on their agenda.

The same thing I'm working on with the department chairs of pediatrics around the country, what's in it for them to partner with all of you around quality improvement and children's health care. Well their faculty have access to data they're interested in publishing. You're interested in somebody interpreting your data and making recommendations for improvement.

So if we could get those people--I actually ran up to my room to do something and my cell phone went off and it was the dean of the college of medicine who was in New York City running in to talk to a big funder who was going to--he was hoping to get money and he asked me all these questions about VCHIP. He just stated about two months ago. Do I have data? Do you have this? Do you have that? I got to go. I got to go. And I thought oh my gosh, I've got to get a report in front of him. I've got to make him articulate so when he gets in front of his colleagues he can talk smartly about this. Make sure your Medicaid directors know how to talk about this. Give them the talking points. Get them educated so they feel confident going into a room talking about this.

There are people that you're not going to change and I know that it's a hard road and I've seen those situations. But making them feel confident in saying look, here's the data in our state and this is how we've beginning to apply it for improvement and this is some of the activities that we're doing and these are some of the ways we're measuring the effectiveness and the impact. Or put it back on them to say we need the data to look at the impact of these activities on the cost of care. We're not doing that but they also own that as well. It's not just up to all of us. It's up to them as well. So some of those are the strategies.

CHRISTINA BOTHELL: I just wanted to add to what Judy said that if you don't feel like you can be the messenger for whatever reason that you can partner with people who can be. I mean there's Family Voices, there's family groups, there's

the press, there's a lot of people who are interested in bringing the issue of children and children's health and health care quality up to a public level. And like I said before, you have enough data to get you jumpstarted on that. So think about, if you can't be the messenger and be the educator that Judy's talking about, who can and to bring them to the table.

WANDA BARFIELD: One last question and it's the incorporation of businesses. We talk a lot about quality in the context of a medical home but what about retail based clinics which are definitely coming and how would you incorporate them into these collaboratives? Have you?

JUDITH SHAW: I wouldn't.

WANDA BARFIELD: Because they are coming and--

JUDITH SHAW: You know what we--our collaboratives is funded by the Medicaid program and since they--all practices in the state--I mean that's one way to, you know, to differentiate, but I have not--that is a huge, huge challenge, especially with regarding children's health care.

CHRISTINA BOTHELL: Well I have an idea which is to educate consumers about what makes up quality and to know it when they see and to be agents on their own behalf as much as possible because parents and youth who are

receiving quality often don't know what makes up good quality, don't know it if they see it. They know how they're treated as a human being, but they don't often know if what's happening is the right thing and they are not stupid and they can learn about it and you can educate them about it and they can go a long way to being empowered on their own behalf. So that's the very first thing and the minimal thing and the next is to make sure that they have the same kind of regulations and requirements for quality improvement that everyone else does.

WANDA BARFIELD: So in conclusion I just want to thank everyone for attending this session and now we're going out to the next set of sessions.