This brief highlights the major strategies, lessons learned, and outcomes from South Carolina’s experience during the first 5 years of the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality is leading the evaluation of the program.

South Carolina engaged practices in pediatric quality improvement activities

South Carolina convened a learning collaborative to help 18 child-serving practices use child health quality measures, implement components of the patient-centered medical home, and integrate mental health services. Over the course of the demonstration, participating practices—

- **Built their quality improvement (QI) capacity.** The State offered practices a range of technical assistance (TA) opportunities, including twice yearly in-person learning collaborative sessions, frequent group conference calls and QI workshops, and individualized support provided by CHIPRA demonstration staff (the Medicaid director, a behavioral health expert, and a QI specialist). Practices learned how to use patient chart data to track CMS’s Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Practices received quarterly stipends for participation and took advantage of opportunities to earn Maintenance of Certification credit for completed QI projects. Most practices reported an increase in their commitment to and capacity for QI as a result of their participation in the learning collaborative.

- **Increased use of developmental, health risk, and mental health screenings.** South Carolina developed a screening protocol that included six developmental and psychosocial screenings for use with infants through adolescents during well-child visits. The learning collaborative provided training in screenings, guidance on accessing community resources, and information on reimbursement procedures. Initially, some practices were concerned about the time and skills needed to incorporate screenings into visits. They pointed to insufficient community resources to address needs identified by the screenings and were confused about reimbursement. However, by the end of the learning collaborative, all 18 practices reported regularly using at least one developmental screening (up from 7 practices at the start of the collaborative), and many had incorporated mental health or other screenings into routine practice.

- **Enhanced behavioral health services.** Per self-report, practices strengthened their ability to deliver pediatric mental and behavioral health services. In addition to the routine use of behavioral and mental health screening tools, clinicians reported more consistent development of care plans for patients with behavioral health issues. They also reported an increase in their knowledge of community behavioral and mental health resources and more frequent provision of referral assistance and care coordination for children and families with behavioral health needs.

- **Improved quality of pediatric health care.** Demonstration staff reported that practices increased families’ access to care, provided oral health preventive services more regularly, and improved adherence to

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**South Carolina’s Goals:** Improve quality of care for children by—

- Helping practices implement the medical home model and integrate physical and mental health services.
- Using electronic health records to calculate and report quality measures for practices in order to guide quality improvement efforts.
national guidelines for asthma, obesity, and attention
deficit hyperactivity disorder care. In addition, practices
made modest improvements in all six domains of the
Medical Home Index–Revised Short Form (Figure 1). To
date, five practices have received medical home
recognition from the National Committee for Quality
Assurance (NCQA) while 10 more are working toward
recognition. However, some practices reported difficulty
in aligning NCQA’s requirements with improved
pediatric care processes.

Figure 1. Changes in Medical Home Index–Revised Short
Form domain-level scores for South Carolina practices

<table>
<thead>
<tr>
<th>Domains</th>
<th>2012 (N = 17)</th>
<th>2014 (N = 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Capacity</td>
<td>4.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Chronic Condition</td>
<td>4.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Management</td>
<td>4.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Community Outreach</td>
<td>5.4</td>
<td>5.8</td>
</tr>
<tr>
<td>Data Management</td>
<td>4.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>4.8</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Note: Data were reported by South Carolina and not independently validated. Baseline data are only available for 17 out of the 18 participating practices.

South Carolina produced quality reports for a subset of participating practices

South Carolina initially intended to produce practice-
level quality reports on the Child Core Set by combining
Medicaid claims data with electronic health record (EHR)
data from the 18 practices participating in the learning
collaborative. The reports would then allow practices
to identify areas needing improvement, track progress,
and compare themselves with peers. However, the State
was able to achieve only limited success, largely because
of difficulties in developing the infrastructure and
functionality needed to record and transfer pediatric data
from practices’ EHRs to the State. The diversity of and
needed modifications to practices’ EHRs complicated and
delayed data extraction. In addition, some practices lacked
an EHR. Nevertheless, the State—

- **Produced quality reports for 7 practices on 15 quality measures.** The State received and processed data from
7 of 18 practices and generated practice reports on 15 of
26 Child Core Set measures, including well-child visits,
immunizations, dental services, emergency department
visits, chlamydia screening, and body mass index
screening. However, given the variation in the quality
and completeness of practices’ data, practices could not
compare their own outcomes over time or with those of
other practices.

Key demonstration takeaways

- Using a learning collaborative model, South Carolina
provided 18 child-serving primary care practices with
TA to implement QI activities, strengthen their medical
home features, and integrate physical and behavioral
health. Practices appreciated the flexibility to establish
their own QI priorities and placed a high value on
learning from other practices.

- South Carolina educated clinicians about the importance
of routine screening, referral and community resources,
and reimbursement strategies for behavioral and
mental health services. In response, practices reportedly
increased their capacity to identify and address patients’
behavioral health needs.

- The State faced greater challenges than expected in
linking EHR and administrative data to produce
practice-level quality reports. Challenges included the
diversity of EHR products used by practices, the labor
required to develop the infrastructure and functionality
needed to transfer data from EHRs to the State, and data
consistency and completeness. Nonetheless, the State
was able to produce reports for some practices on a
limited number of Child Core Set measures.
South Carolina’s CHIPRA quality demonstration experiences are described in more detail on the national evaluation Web site at http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/sc.html.

The following products highlight South Carolina’s experiences—

- **Evaluation Highlight No. 2:** How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?
- **Evaluation Highlight No. 5:** How are CHIPRA quality demonstration States encouraging health care providers to put quality measures to work?


- **Reports from South Carolina:** South Carolina published a toolkit to provide guidance and insight into the patient centered medical home transformation process.

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**Endnotes**


2. For more information on the Medical Home Index, visit http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/demoeval/what-we-learned/highlight02.pdf.

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**Continuing Efforts in South Carolina**

South Carolina will continue pursuing its CHIPRA quality demonstration activities until February 2016 under a grant extension approved by CMS. Moving forward, South Carolina will—

- Establish a pediatric quality unit within the State’s Medicaid program.
- Expand the learning collaborative to work with additional pediatric practices, using funding in the 2015–2016 State budget.
- Develop and disseminate a series of issue briefs on promising practices and lessons learned through the demonstration.

The information in this brief draws on interviews conducted with staff in South Carolina agencies and participating practices, an analysis of Medical Home Index data submitted by South Carolina, and a review of project reports submitted by South Carolina to CMS.

The following staff from Mathematica Policy Research and the Urban Institute contributed to data collection or the development of this summary: Dana Petersen, Christal Ramos, Emily Lawton, and Amanda Napoles. Margarita Hurtado also contributed to data collection.