



## Spotlight on Idaho

July 2015

This brief highlights the major strategies, lessons learned, and outcomes from Idaho'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.

### Child-serving practices strengthened their medical home features

Idaho helped three child-serving practices (two primary care and one specialty) implement components of the patient centered medical home (PCMH) model—an approach to care aimed at improving care coordination, quality, and patient engagement. The State focused specifically on improving care for children with special health care needs (CSHCN). Idaho—

- **Provided technical assistance to three practices.** Idaho modeled their approach to technical assistance after Utah's and included group in-person learning activities and individualized support from quality improvement (QI) coaches. Practices had access to a Web-based platform to report on progress of QI efforts, and clinicians were eligible to receive Maintenance of Certification credit for completed QI projects. Clinicians and practice staff reported that they valued the support of QI coaches and the opportunity to learn from each other, especially when analyzing and interpreting data.
- **Supported care coordination staff.** Idaho used demonstration funds to hire care coordinators, typically individuals with some health care or other relevant expertise, to strengthen practices' ability to deliver care for CSHCN. The care coordinators were

**Idaho's Goals:** Improve quality of care for children by—

- Helping practices implement the patient-centered medical home model.
- Promoting the use of health information technology.
- Establishing a pediatric improvement partnership.

**Partner State:** Idaho and Utah implemented similar projects and met regularly to discuss shared lessons.

embedded within the practices. They attended learning collaborative sessions, implemented new care processes (such as developing care plans for CSHCN, linking patients with community resources, and making reminder calls to parents of children who missed visits), and tracked progress toward practice goals. All three practices valued the contributions of the care coordinators and have committed to sustaining the position after the demonstration funding ends.

“Families say they are really appreciative of my efforts and the fact that I offered to do care coordination for them so that they can just be a mom or dad—just relieve a little bit of stress.”

— Idaho Care Coordinator, December 2013

- **Introduced family partners in practices.** Idaho encouraged practices to engage family partners (typically parents of CSHCN) to advise them on how to provide more family-centered care and provide peer support to other families. Family partners were to receive stipends to partially compensate for their time working with the practice. However, practices faced challenges in integrating family partners, including clinicians' resistance to working with lay advisors and difficulty in finding parents with available time and the appropriate skills (such as the ability to communicate effectively with other parents). Ultimately, one practice used family

partners as originally intended, one could not overcome challenges and thus did not engage family partners, and one developed a parent advisory committee (in lieu of working with a single partner) to capitalize on the strengths of, and spread the work among, many parents.

- **Spread the learning collaborative model to four additional rural practices.** Staff from the Idaho Maternal and Child Health Bureau and Department of Public Health sought support from demonstration staff to develop and implement a medical home initiative—modeled after the CHIPRA learning collaborative—in four rural practices. Demonstration staff supported the initiative by developing the learning curriculum and running learning collaborative sessions, training care coordinators, and offering QI coaching support.

## Idaho used information technology (IT) to improve the quality of health care for children

Idaho adopted two IT strategies to improve health information exchange and enhance care coordination. Using demonstration funds, Idaho—

- **Laid the groundwork to exchange immunization data within the State and with Utah.** Because many Idaho children receive immunizations in Utah, Idaho is building the infrastructure needed for the exchange of data between Idaho clinicians and also with Utah's health information exchange (HIE). However, Idaho law currently prohibits bidirectional exchange of immunization data. The desired next steps—(1) practices submit immunization data directly to the HIE and download data from the HIE to their local electronic health records, and (2) the Idaho and Utah HIEs are linked to permit the bidirectional sharing of immunization data—will not be possible until Idaho law is amended.
- **Contributed content to an online resource to help physicians and parents care for CSHCN.** Idaho hired staff to develop content for the newly created Idaho section of the Medical Home Portal,<sup>1</sup> which provides information on care and community resources for CSHCN. Staff uploaded local and State resources, including contact information for and descriptions of more than 2,000 clinicians and community organizations.

## Idaho established a pediatric quality improvement partnership

Idaho met regularly with and applied lessons learned from Utah to establish a statewide pediatric improvement partnership, the Idaho Health and Wellness Collaborative for Children (IHAWCC).<sup>2</sup> IHAWCC is a coalition of clinicians and stakeholders—including representatives from the State's Medicaid program, professional associations, private payers, and local health care systems—invested in using measurement-based efforts to improve the quality of children's health care. With guidance from Utah, IHAWCC—

- **Offered learning collaboratives to more than 100 clinicians statewide on a variety of pediatric topics.** IHAWCC's collaboratives addressed, for example, immunizations, childhood obesity, adolescent care transitions, adolescent depression screening, and diagnosis and treatment of attention deficient hyperactivity disorder. Each collaborative included a group kick-off learning session (either in person or via Webinar to extend reach to rural practices), followed by conference calls with experts, training in how to implement process improvements, and individualized support from a QI coach to review progress and create plans to sustain changes.
- **Enhanced QI capacity and health care quality.** Demonstration staff reported that participating clinicians gained valuable QI skills as demonstrated by measureable improvements in the use of best practices and the quality of care they provide. For example, use of validated depression screening tools reportedly increased from 2 to 51 percent among 60 clinicians after their participation in the adolescent screening collaborative. Similarly, practices reported that screening for substance use and abuse increased from 18 to 58 percent.

## Key demonstration takeaways

- Idaho engaged stakeholders within the State and drew on Utah's experiences to launch the State's first medical home transformation initiative and QI learning collaboratives for child-serving providers, including those in rural areas.
- Practices used demonstration funds to hire new staff to improve care coordination and support medical home

transformation. All three practices have committed to sustaining care coordinator positions with their own funding.

- Idaho encountered statutory barriers to using the State's HIE to share immunization data among clinicians in Idaho and also with Utah. Nonetheless, the State began laying the groundwork for data exchange after resolution of the statutory barriers.

## Endnotes

1. For more information on the Medical Home Portal, visit <http://www.medicalhomeportal.org/>.
2. For more information on the improvement partnership, visit <http://www.ihawcc.org/#aboutus>.

### Continuing Efforts in Idaho

Idaho will continue pursuing its demonstration activities until February 2016 under a grant extension approved by CMS. Moving forward—

- Idaho will apply lessons from the demonstration to implement future care coordinator and family partner activities.
- Idaho will disseminate a toolkit—based on lessons learned from the PCMH learning collaborative—to help other practices implement changes.
- Idaho will continue to support and expand the State's HIE development.
- IHAWCC will seek funding and support from the State's children's hospital to continue developing QI capacity and offering learning collaboratives statewide.

## LEARN MORE

Idaho's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Website at <http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/id.html>.

The following products highlight Idaho's experiences—

- *Evaluation Highlight No. 2:* How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?
- *Evaluation Highlight No. 6:* How are the CHIPRA quality demonstration States working together to improve the quality of health care for children?
- *Evaluation Highlight No. 7:* How are CHIPRA quality demonstration States designing and implementing caregiver peer support programs?
- *Evaluation Highlight No. 9:* How are CHIPRA quality demonstration States supporting the use of care coordinators?
- *Evaluation Highlight No. 13:* How did CHIPRA quality demonstration States employ learning collaboratives to improve children's health care quality?
- *Implementation Guide No. 1:* Engaging Stakeholders to Improve the Quality of Children's Health Care

The information in this brief draws on interviews conducted with staff in Idaho agencies and participating practices and a review of project reports submitted by Idaho to CMS.

The following staff from Mathematica Policy Research contributed to data collection or the development of this summary: Dana Petersen and Lisa Schottenfeld.