

Spotlight on Massachusetts

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This brief highlights the major strategies, lessons learned, and outcomes from Massachusetts's experience in 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

Massachusetts helped 13 practices implement components of the patient-centered medical home (PCMH) model—a primary care model aimed at improving care coordination, access to services, and patient engagement. Through a learning collaborative, the State educated the practices on the medical home model and provided a structure and process through which the practices could learn from each other. Each practice received \$1,150 per month to support its work under the demonstration and—

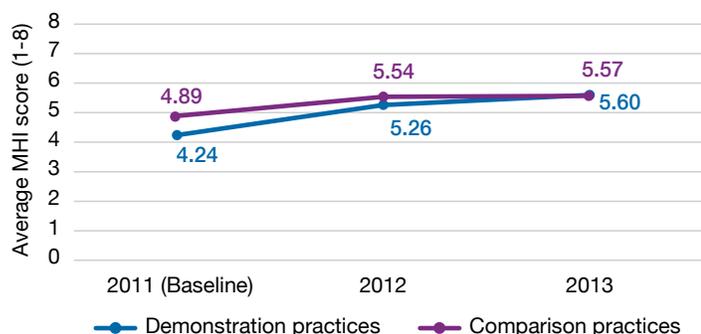
- **Developed quality improvement teams.** Each practice's quality improvement (QI) team included a senior leader, clinician champion, practice facilitator (a staff member assigned to lead QI projects), and family partner (a caregiver who volunteered to advise the practice on QI projects). Some practices experienced difficulty in defining the role of families as improvement partners, and managing family partner turnover posed a challenge to the QI teams. In response, demonstration staff developed a guide for practices to help them engage families.¹

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

- Helping practices implement the patient-centered medical home model.
 - Reporting on child-focused quality measures.
 - Developing a coalition to lead quality improvement efforts in the State.
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- **Improved care coordination for children.** Practices modified the job responsibilities of existing staff to include care coordination duties. Care coordinators supported the practices' PCMH efforts in many ways, such as by following up with caregivers of children diagnosed with conditions such as autism, attention deficit hyperactivity disorder, and asthma to see if they received needed services. The State used demonstration funds to hire Massachusetts Department of Public Health (DPH) staff to provide weekly training for care coordination staff at each practice. However, some practices reported that working with DPH staff on that schedule was disruptive to practice flow. In response, the State allowed these practices to work with DPH on an on-call basis. Ultimately, practices valued care coordinator contributions. A few practices expressed concern about retaining care coordinators after the demonstration ends because of the lack of reimbursement for care coordination activities.
 - **Improved EHR use.** Most practices started extracting data from their electronic health records (EHRs) to identify children with special health care needs. Some practices used their own funds to hire new employees to help them use EHRs more effectively.

- **Increased medical home features.** Demonstration practices increased their Medical Home Index scores at a faster rate than comparison practices (Figure 1).²

Figure 1. Increase in the average Medical Home Index score in Massachusetts's participating practices



Note: Data are reported by Massachusetts and not independently validated.

Massachusetts produced quality reports for clinicians, families, and policymakers

To drive QI activities, Massachusetts calculated the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)³ and produced quality reports that compared practices' performance to national benchmarks. Using demonstration funds, the State—

- **Collected and reported to CMS on 22 out of 26 Child Core Set measures.** The State reported on Medicaid, CHIP, and commercially insured patients by linking data from several sources, including the 13 demonstration practices, health plans, and the State's new database that stores Medicaid and commercial data. Moreover, to report on the patient experience measure, Massachusetts fielded a standardized survey on caregiver perceptions of care in Medicaid and CHIP.⁴
- **Produced quality measure reports for practices, families, and policymakers on Medicaid, CHIP, and commercially insured patients.** The State conducted interviews with 10 practices and focus groups with 30 families to obtain feedback on the usability of the reports and then used the feedback to improve the reports. Though the process of interpreting measure specifications and developing legal agreements to access needed data was more time-intensive than expected, the State reported that its efforts ultimately yielded robust and useful reports.

Massachusetts formed the Child Health Quality Coalition to lead the State's child health QI efforts

Using CHIPRA quality demonstration funds, Massachusetts formed a multistakeholder group—the Children's Health Quality Coalition—representing clinicians, payers, State and local government agencies, family advocacy groups, and individual parents and families.⁵ The coalition's executive director position turned over three times during the grant period, thus hampering coalition activities. Nevertheless, the coalition—

- **Identified problems with the quality of children's health care.** Demonstration staff collected data from a variety of local and national sources to produce child health quality reports for the coalition's analysis of gaps in care. After reviewing the reports, the coalition identified three priority areas for its QI work: (1) promoting care coordination, (2) reducing unnecessary emergency department visits, and (3) building measurement capacity.
- **Developed resources to help practices and families improve quality of care.** The coalition developed two tools to support QI efforts. The resources included data templates that allow practices to track adoption of care coordination activities as well as a communication guide that facilitates effective communication among a child's primary care provider, speciality care providers, school, and family. To encourage adoption of the resources, the coalition posted them on its Web site and continuously promoted them with providers and families. It also educated providers and families on how to use the resources.

Key demonstration takeaways

- Massachusetts indicated that families' input on PCMH transformation, quality reporting, and QI priorities proved helpful. Even though some practices needed guidance on how to work with family partners as a member of their QI teams, the State reported that practices recognized the value of engaging families in QI activities.
- Practices reported that designating staff to provide care coordination improved care. However, without payment for care coordination, some practices may be unable to sustain these activities.

- The State increased the quality, transparency, and visibility of children’s health by forming a multistakeholder coalition and producing reports for practices, families, and policymakers that cover Medicaid, CHIP, and commercially insured populations. The State reported that it will need to identify other sources of funding to continue the coalition’s work beyond the demonstration.

Endnotes

1. The family engagement guide is available at <http://medicalhome.nichq.org/resources/family%20engagement%20guide>.
2. For more information on the Medical Home Index, visit <http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/highlight02.html>.
3. For more information on the Child Core Set, visit <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.
4. Massachusetts used the Consumer Assessment of Healthcare Providers and Systems (CAHPS)—PCMH Survey. For more information, visit <https://cahps.ahrq.gov/>.
5. For more information on the coalition, visit <http://www.mhqp.org/collaboration/chqc.asp?nav=063700>.

Continuing Efforts in Massachusetts

Following the CHIPRA quality demonstration grant—

- Practices plan to maintain changes and pursue additional QI activities. To that end, a few practices plan to use their own funds to sustain care coordinators and family partners.
- The Children’s Health Quality coalition is investigating funding sources, including dues from member organizations, philanthropy, and grant funding, to continue its work and share newly developed products with practices and families throughout the State.

LEARN MORE

Massachusetts’s CHIPRA quality demonstration experiences are described in more detail on the national evaluation Web site available at <http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/ma.html>.

The following products highlight Massachusetts’s experiences —

- *Evaluation Highlight No. 1:* How are CHIPRA demonstration States approaching practice-level quality measurement and what are they learning?
- *Evaluation Highlight No. 2:* How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?
- *Evaluation Highlight No. 4:* How the CHIPRA quality demonstration elevated children on State health policy agendas
- *Evaluation Highlight No. 9:* How are CHIPRA quality demonstration States supporting the use of care coordinators?
- *Evaluation Highlight No. 11:* How are CHIPRA quality demonstration States using quality reports to drive health care improvements for children?
- *Evaluation Highlight No. 13:* How did CHIPRA quality demonstration States employ learning collaboratives to improve children’s health care quality?
- *Article:* Devers K, Foster L, Brach C. Nine states’ use of collaboratives to improve children’s health care quality in Medicaid and CHIP. *Acad Pediatr* 2013; 13 (6): S95-102. PMID: 24268093.
- *Implementation Guide No. 1:* Engaging Stakeholders to Improve the Quality of Children’s Health Care.
- *Reports from States:* Massachusetts produced reports on the collection and use of core measures for families and providers, findings from the patient experience survey, and the learning collaborative to improve quality of care.

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

The following staff from Mathematica Policy Research and the Urban Institute contributed to data collection or the development of this summary: Mynti Hossain, Grace Anglin, Rebecca Peters, Adam Weiss, and Emily Hayes. Margarita Hurtado also contributed to data collection.