

Spotlight on Maine

July 2015

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

Maine expanded State-level reporting and use of child-focused quality measures

Maine worked with a variety of stakeholders to increase reporting and use of pediatric quality measures, including CMS's Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).¹ Using demonstration funds, Maine—

- **Increased the number of Child Core Set measures reported to CMS from 14 to 18.** The State added a new billing code modifier to distinguish between global developmental and autism screenings, thereby permitting the State to report on the rates separately. The State also identified ways to use health information exchange (HIE) data to calculate measures. However, the State was unable to report on all 26 measures because of the limited availability of administrative data on behavioral health services and clinical data from practices' electronic health records (EHRs).
- **Formed the Maine Child Health Improvement Partnership (ME CHIP) focused on quality improvement (QI).** The workgroup brought together representatives from practices, child advocacy organizations, professional associations, payers, and the public health system.² ME CHIP developed a master list of pediatric quality measures that includes the Child

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

- Increasing State-level reporting and use of child-focused quality measures.
- Helping practices implement quality improvement projects.
- Developing a secure electronic method for primary care providers to access health information for children in foster care.

Partner State: Maine and Vermont implemented similar projects and met regularly to discuss shared lessons.

Core Set and additional measures deemed important for QI. Maine indicated that, even though broad stakeholder involvement helped the State gain support for selected measures, it sometimes experienced difficulty in gaining consensus given the wide range of viewpoints represented.

- **Disseminated annual reports on statewide performance on 21 measures (including 18 Child Core Set measures).** Following the above efforts, Maine Medicaid and the State's public reporting program started monitoring additional Child Core Set measures. The State also implemented strategies to improve measure performance. For example, the State began allowing primary care providers to bill for oral health evaluations conducted in their offices for any child under age 3 who had not previously visited a dentist.

Maine providers improved performance on quality measures

Maine provided practices with comparative quality data and technical assistance to help them increase the delivery of preventive services. Under the CHIPRA quality demonstration, Maine—

- **Expanded practice-level reporting.** The State improved a system that allows practices to generate real-time reports on immunization measures from the State's immunization registry. Maine also added five Child Core Set measures to the existing claims-based reports

available to practices twice a year. Practices found the reports useful for targeting improvement strategies, but long delays in claims processing and infrequent reporting created barriers to the reports' use in tracking performance. The State helped interested practices run reports from their EHRs or conduct chart reviews, enabling the practices to obtain more timely information between reporting periods.

- **Hosted learning collaboratives focused on immunizations, developmental screening, oral health, and healthy weight.** ME CHIP worked with the State to select the topic for each 9-month learning collaborative. The collaboratives engaged anywhere from 12 to 34 practices, and sessions involved a mix of activities, including in-person meetings, monthly Webinars, individualized technical assistance from a practice coach, and opportunities for clinicians to receive Maintenance of Certification credit. Practices were most likely to participate in collaboratives that aligned with nondemonstration initiatives offering payment incentives for improved performance.
- **Helped practices improve performance on quality measures.** Practices implemented various new strategies, including using the State registry to identify patients due for immunizations, developing processes to remind families when a child was due for screening, conducting oral evaluations, and embedding reminders in EHRs to counsel patients about oral health and healthy eating. Practices demonstrated improvement in most areas, with the greatest improvements in developmental screening rates (Figure 1). Still, some practices faced challenges in spreading new strategies throughout their practices and sustaining changes after the learning sessions. In addition, some practices were hesitant to provide counseling on healthy weight because they were unsure how best to encourage lifestyle changes or felt parents were uncomfortable discussing the topic.

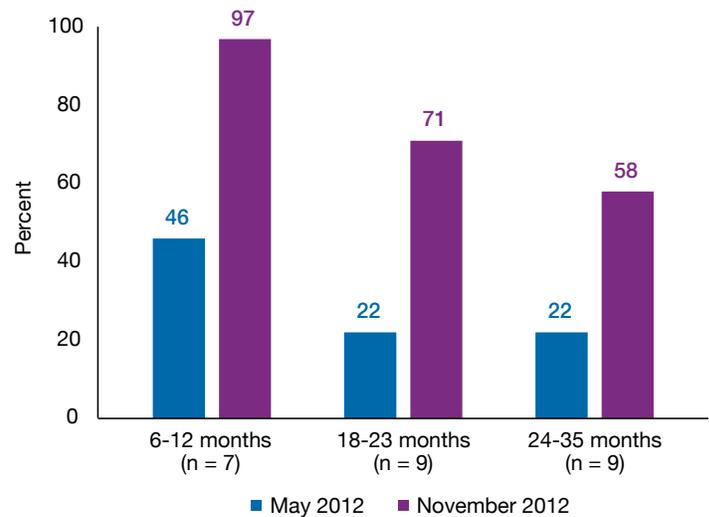
Maine piloted an electronic process to share health information for children in foster care

During the demonstration, children entering the State's foster care system in 6 of Maine's 16 counties received a Comprehensive Health Assessment (CHA) from

a contracted provider. Going beyond the standard assessment completed for all children in foster care, the CHA incorporates information from a physical examination, behavioral health evaluation, and health and other social service records. The State used demonstration funds to ease use of the CHA and pilot test using the State's HIE to store and share the CHA records. Maine—

- **Developed a process for CHA documents to be securely uploaded and retrieved from the State's HIE.** The State engaged several clinical consultants and pediatric primary care practices in planning and developing the information-sharing process and then pilot tested it with one State-contracted CHA provider. However, the time required for the State to resolve technical and legislative barriers associated with the State HIE delayed efforts to expand the pilot.

Figure 1. Increases in developmental screening rates for practices participating in Maine's developmental screening learning collaborative



Note: Data were reported by Maine and not independently validated. The State analyzed data for participating practices that submitted chart data for review.

Key demonstration takeaways

- Engaging stakeholders in the identification of quality measures to be tracked and topics to be addressed in learning collaboratives helped Maine improve consistency in measure reporting and encouraged practices to participate in QI activities.

- Learning collaboratives, clarified billing guidance, and enhanced reporting functions within the State's immunization registry helped practices build capacity and improve performance on quality measures, particularly developmental screening rates.
- Maine's efforts to report quality measures at the State level and share CHA information through the HIE were limited by complexities related to sharing behavioral health information, variations in connectivity, and child health providers' use of the HIE. Nonetheless, the State was able to produce quality reports and plans to expand its pilot for electronic sharing of CHA information.

Continuing Efforts in Maine

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

- Maine plans to continue generating quality measure reports showing performance at the State and practice levels. The State will apply lessons learned in quality reporting to other quality measurement initiatives.
- Practices plan to sustain many of their QI strategies.
- Maine plans to continue developing its pilot for securely sharing health information for children in foster care in support of eventual statewide implementation.

Endnotes

1. 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>.
2. For more information on Maine's master list of quality measures, visit <http://www.maine.gov/dhhs/oms/provider/ihoc.shtml>.

LEARN MORE

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

The following products highlight Maine'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. 6:* How are the CHIPRA quality demonstration States working together to improve the quality of health care for children?
- *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.
- *Reports from States:* Maine produced reports on the collection and use of core measures, electronic exchange of pediatric data, and learning collaboratives to improve quality of care.

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

The following staff from Mathematica Policy Research and the Urban Institute contributed to data collection or the development of this summary: Grace Anglin, Kelly Devers, Rachel Burton, Emily Lawton, and Amanda Napoles.