

A Case Study of Improvement Partnerships in New Mexico and Oregon

Evolving State Quality Improvement Infrastructure and the Role of Improvement Partnerships and NIPN

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Executive Summary

Improving health care quality and outcomes is in the spotlight as never before, with reporting on outcomes and incentives to enhance performance central features of the Affordable Care Act (ACA) and Accountable Care Organizations. Many states also are reforming their Medicaid programs, using such policy levers as quality monitoring and incentives, to reduce costs and to improve quality. Merely providing incentives to improve quality may not offer sufficient guidance to practices or physicians. Incentives, coupled with on-the-ground support for practices to show practices *how to improve* may be needed for optimal results. Indeed, the combination of “*pull*” from external incentives and “*push*” from practice-level improvement support could be more successful in bringing about improvements than pursuing either by itself.

Vehicles for such on-the-ground quality improvement (QI) support include Improvement Partnerships (IP) at the state level. State-level IPs generally focus on the Medicaid pediatric population, and use classic Improvement Science methods to bring about better health care outcomes. The purpose of this report is to investigate the ways in which these IPs serve as effective vehicles for sustainable broader systems-level QI efforts. Two existing IPs whose work was supported and enhanced as part of a set of quality demonstration projects authorized under the Children’s Health Insurance Reauthorization Act (CHIPRA) of 2009 are explored in detail. CHIPRA also provided part of the funding for an umbrella group, the National Improvement Partnership Network (NIPN), which was established in 2009 to support existing IPs and help foster new IPs.

This report examines the quality incentive structure within which IPs operate, the outcomes individual IPs have been able to achieve, and the role the NIPN plays in assisting local IPs with their improvement efforts and in functioning as a learning health care system. Described are case studies of established IPs in New Mexico and Oregon, two states that recently implemented major changes to their Medicaid programs. These transformed systems have significant implications for QI in each state. The development of the case studies involved reviewing relevant literature in each state about the IP and state QI initiatives, as well as conducting on-site interviews with representatives of state Medicaid agencies, managed care organizations, physician practices, and IP staff.

Each case study begins with an examination of the QI initiatives, strategies and roles of the state’s IP, followed by a description of the state Medicaid reforms, and the IPs’ future role in the evolving QI infrastructure. The final section of the paper discusses the value of NIPN to IPs and recommended future steps for NIPN.

This case study report illustrates the pivotal role played by New Mexico’s IP called Envision, and Oregon’s IP called, OPIP. This report looks at their state-level QI efforts to improve primary care for children and adolescents. Individuals interviewed for this case study widely acknowledged that IPs play multiple roles in their states such as : encouraging and supporting QI through coaching and training; practice facilitation; and serving as intermediaries between physicians, managed care organizations and state Medicaid agencies. Beyond their QI role, IPs also are working on broader issues such as preparing practices to operate within the evolving

Medicaid quality incentive framework in New Mexico and Oregon, as well as assuming a role in policy discussions in Oregon.

The two IPs examined in this case study operate in a similar environment. Both states' Medicaid programs have very recently undergone significant transformations "that reserve" reforms key role for MCOs in New Mexico and CCOs in Oregon. These organizations are guided by the "pull" of incentives at the heart of their states' transformed Medicaid systems. Medicaid reforms position MCOs and CCOs to control the funding levers which financially reward plans meeting quality measures. These reform changes provide the IPs with both opportunities and challenges to provide the on-the-ground "push" to support and advance QI at the state level.

The evolving QI environments in New Mexico and Oregon, with their attendant focus on specific incentive measures, allow Envision and OPIP to build on and showcase the depth and breadth of their expertise. The heightened focus on advancing QI through the development of a robust care coordination capacity within practices as well as the ongoing transformation of practices to PCMHs will work to the advantage of IPs such as Envision and OPIP, which have significant experience supporting such changes.

Key informants involved in IP initiatives in both New Mexico and Oregon expressed great appreciation and enthusiasm for NIPN. Those interviewed underscored the value to them of a national network for state-level IPs in general, as well as the specific assistance and leadership NIPN has provided to them in their efforts to improve the quality of health care for children and adolescents in their respective states. NIPN has worked to support state-level IPs as they have developed public-private partnerships and created a "common table" and an effective, streamlined infrastructure for QI in their states.

NIPN has provided vital support for existing and emerging IPs, and in so doing has been instrumental in significantly advancing QI efforts in numerous states during its first five years of existence. IPs are involved in crucial initiatives in the two states examined here, with one key informant noting that to achieve the level of translation of public policy to practice-level transformation would be "almost impossible" without a functional IP operating in the state." The role that IPs play in such translational work is unique, as in the words of one interviewee: it "is not going to happen through the state or federal government; it has to have a different venue for it to gain traction." NIPN is at a crossroads with many opportunities ahead to continue to advance QI initiatives and strengthen the QI infrastructure within and across states. IPs look to NIPN to be a major force for QI on a national level.

I. Introduction

Improving health care quality and outcomes is in the spotlight as never before, with reporting on outcomes and incentives to enhance performance central features of the Affordable Care Act (ACA) and Accountable Care Organizations. Many states also are reforming their Medicaid programs, using such policy levers as quality monitoring and incentives, to reduce costs and to improve quality. Merely providing incentives to improve quality may not offer sufficient guidance to practices or physicians. Incentives, coupled with on-the-ground support to show practices *how to improve* may be needed for optimal results. Indeed, the combination of “*pull*” from external incentives and “*push*” from practice-level improvement support could be more successful in bringing about improvements than pursuing either by itself.

Vehicles for such on-the-ground quality improvement (QI) support include Improvement Partnerships (IP) at the state level. State-level IPs are public-private collaborations that generally focus on the Medicaid pediatric population, and use classic Improvement Science methods (e.g., monitoring outcomes, identifying areas for improvement, implementing Plan-Do-Study-Act (PDSA) cycles for areas that need improvement and monitoring again) to bring about better health care outcomes.ⁱ

The purpose of this report is to closely examine the ways in which IPs provide support for broader systems-level QI efforts. Two existing IPs whose work was supported and enhanced as part of a set of quality demonstration projects authorized under the Children’s Health Insurance Reauthorization Act (CHIPRA) of 2009 are explored in detail. CHIPRA also provided part of the funding for an umbrella group, the National Improvement Partnership Network (NIPN), which was established in 2009 to support existing IPs and help foster new IPs. NIPN provides critical technical assistance to IPs in the form of experience-informed strategies, tools and processes for QI, and offers IPs a variety of ongoing learning opportunities.ⁱⁱ NIPN currently counts more than 20 states among its expanding active membership.

This report examines the incentive structure within which IPs operate, the outcomes individual IPs have been able to achieve, and the role the NIPN plays in assisting IPs with their improvement efforts and in functioning as a learning health care system. This was accomplished through case studies of established IPs in New Mexico and Oregon, two states that recently implemented major changes to their Medicaid programs. As described in the following sections, these transformed systems have significant implications for QI in each state.

II. Methods

The development of the IP case studies involved reviewing relevant literature about the IPs, NIPN and state QI initiatives. AcademyHealth also conducted on-site interviews with representatives of state Medicaid agencies, managed care organizations, provider practices and IP staff. The detailed case study methodology is found in Appendix A.

In each case study, we begin with an examination of the roles, initiatives and strategies of the IPs, followed by a description of the state Medicaid reforms, and the evolving QI environment within the state. Finally, we discuss the challenges and opportunities for the IPs in the changing QI environment. The report concludes with a discussion of the value of NIPN to IPs and recommended next steps for NIPN.

III. New Mexico Case Study

Envision New Mexico

Envision New Mexico (Envision NM), one of the most mature IPs within NIPN, has been in existence for 10 years. Housed within the Department of Pediatrics of the University of New Mexico Health Sciences Center (UNMHSC), Envision NM works in partnership with the UNMHSC, the New Mexico Medicaid Program, the New Mexico Department of Health and the New Mexico Pediatric Society (see Table 1). Envision operates within a primarily rural state with a majority minority population—nearly 50 percent of the population is Hispanic or Latino and 10 percent American Indian—marked by high levels of poverty. Nearly one in three children under the age of 18 in the state live in poverty.ⁱⁱⁱ More than one-quarter of the population receives health care services through the Medicaid program, including nearly 70 percent of all children. Approximately 175,000 beneficiaries will be added to the program as a result of the expansion of Medicaid under the ACA.^{iv}

QI Initiatives

Envision New Mexico is at the forefront of QI efforts critical to children's and adolescent health care in a number of key areas, including: asthma, developmental screening, pediatric overweight, and Patient-centered Medical Home (PCMH).. Envision employs telehealth technology to extend access and expertise across the predominantly rural state. In addition, Envision provides Maintenance of Certification (MOC) training in three areas: asthma, pediatric asthma, developmental screening, and pediatric overweight.. Outcomes measures related to Envision's efforts to increase documentation rates for overweight and asthma at 5 MOC sites are found in Appendix B.

Earlier this year, Envision secured a contract with a Medicaid managed care organization to work with five practices on QI for diabetes and asthma. Envision will use their QI practice facilitation model to work with providers to improve adherence to evidence-based guidelines, reduce the number of ER and hospital visits, and develop a patient-centered approach to health care delivery.

Envision also is broadening its reach into new program areas, having been awarded a new contract to work with GRADS, a pregnant and parenting teens program. Envision will implement its standard QI approach to data collection, reporting, coaching calls and site visits in this new programmatic environment. Indeed, the IP's strength derives from its "coaching model and practice facilitation model that works no matter what content or what kind of arena we're in—hospital, primary care or school-based health center" according to an Envision representative.

**Table 1. ENVISION NEW MEXICO: The Initiative for Child Healthcare Quality
Summary Overview**

Institutional Home	University of New Mexico Health Sciences Center
Year Established	2004
Mission Statement	To envision <i>what can be</i> and create the highest quality health care for children in New Mexico.
Key Partnerships	New Mexico Medicaid Program New Mexico Department of Health New Mexico Pediatric Society Indian Health Service
Other partners	New Mexico Human Services Department New Mexico Alliance on School-based Health Care New Mexico Salud Managed Care Organizations
Areas of focus of IP projects	Asthma Developmental Screening Medical Home Pediatric Overweight School-based Health Centers
Current IP projects/Number of Practices involved	5 projects Approximately 20 School-based Health Centers (nearly half of all state-funded SBHCs) 19 Maintenance of Certification (MOC) practices
Staffing Level	18.85 full-time equivalent personnel
Total Funding	\$2,059,397
Key Contact	Jane McGrath, Executive Director jmcgrath@salud.unm.edu Envision website: http://envisionnm.org/

CHIPRA Grant

New Mexico and Colorado were recipients of one of the 10 CHIPRA demonstration grants (with Colorado as the lead agency). The overall purpose of the federal demonstration project was to develop and showcase effective QI techniques. Specifically, this grant sought to improve quality in 10 School-Based Health Centers (SBHCs) in New Mexico. Areas targeted for QI include:

- Conduct Early Periodic Screening, Diagnosis and Treatment (EPSDT) examinations
- Increase the percentage of children with up-to-date immunization records
- Increase the percentage of SBHC patients that receive Chlamydia screens
- Improve child and adolescent obesity prevention and treatment by ensuring that Body Mass Index (BMI) screens are conducted and follow-up actions are taken.

The grant also sought to improve youth engagement and to assist sites in transforming into PCMHs. Envision’s role was to work with the 10 SBHCs to improve care, using standard QI techniques. Two important tools were developed as part of this grant: a risk-screening tool that could be administered within a SBHC on an iPad (the electronic Student Health Questionnaire, or eSHQ) and the Youth Engagement in Health Services, or YEHS (this is an instrument to measure youth engagement among adolescent using school-based health centers).

In addition to the CHIPRA project, Envision also has a contract with the New Mexico Department of Health to work with a number of other SBHCs throughout the state.

Stakeholders' Perspective

AcademyHealth staff met with stakeholder representatives to discuss quality improvement efforts in the state as well as their perceptions of Envision New Mexico's role in QI. We interviewed representatives of physician practices, a Managed Care Organization, as well as representatives of the state Department of Health and the state Human Services Department.

Envision's QI work with Physician Practices/Practice Response

The practices with whom we spoke were uniformly positive about Envision NM's involvement in QI activities. While it is important to note that these are practices highly motivated to improve quality, they reported that Envision NM's QI framework was extremely useful to them, particularly as it enabled them to develop approaches to improving care for the management of chronic conditions such as asthma and overweight.

Practice providers spoke to the key role Envision played in helping them to build internal capacity to improve quality of care. One provider explained that they already have systems in place and clear protocols for such things as well child checks or immunizations. The management of chronic care conditions such as asthma and overweight is more difficult for them, however, and it is for these conditions that they need outside assistance. Envision helped the practice to develop uniform tools for the accurate diagnosis, assessment of severity and control of asthma, making laminated information cards to share with all providers. The practice member acknowledged the benefit of working with Envision, explaining that "getting everybody on the same page is very, very helpful."

"I think without Envision we would not be where we are today in providing the kind of quality of care that we are able to give."

Based on the progress made with Envision on their asthma initiative, the practice is now beginning to work on initiatives related to overweight. One provider emphasized that this effort

will be very different from the asthma initiative since "you are not treating a patient, you are treating a family. That is going to be a big challenge."

Another practice interviewed reported that they have worked with Envision on developmental screening, overweight, and quality transformation in practice (QTIP), a special initiative aimed at transforming practices to do team-based care and transition to PCMHs. The practice is now working on their fourth project with Envision, this time on asthma care. The provider found his work with Envision to be inspiring, explaining "that's where my commitment to quality improvement came about."

"They are really good at coaching on the PDSA cycle; [the coach] has got people thinking in that manner."

Practice representatives reported that when the Envision team comes in, they gather the whole

team – receptionists, nurses, medical assistants, and physicians – and begin with team-building exercises that result in team buy-in. Envision uses baseline data to discuss detailed ways to improve quality in a specific area. Each practice team member is encouraged to contribute ideas on what they can do to improve. Then they do a small PDSA cycle to improve one aspect, gather more data, speak with Envision coaches and plan the next step. Practices noted that Envision coaches are very responsive and “always available to help look at the data and give suggestions.”

Another provider interviewed also shared how impressed he was with Envision’s PDSA coaching, which enables the practice to “kind of go our own way and ask for help when we see road blocks.” This low-key approach enabled the practice to build internal capacity; as the interviewee observed: “when it is coming from the outside it doesn’t happen as efficiently as it does when it is coming from the inside.”

Practices reported that Envision’s method of using “small steps” was enormously helpful and that Envision taught the team “how to engage the rest of the practice and how to

“The key to making sustainable improvement is making small changes. Through Envision we were able to do that.”

“sustain the change.” Practice team members also believed that learning the improvement methodology or framework from Envision NM made each successive QI effort a bit easier.

Envision’s work with Managed Care Organization/(MCO) Response

There was only one MCO working extensively with Envision NM at the time of our interviews. The MCO representative we spoke with articulated a clear role and need for outside QI assistance such as that offered by Envision, explaining that while the MCO can set a goal or direction for a practice, the practice might need assistance in order to actually meet the goal. Moreover, it may be difficult for the MCO to supply this “how to” information given that funding flows from MCOs to the practices. Practices may be apprehensive about the consequences of any quality problems that may be revealed. Envision serves an important role as a neutral intermediary between the practices and the MCO.

An independent intermediary such as Envision serves an essential role as the “go-between or neutral group” according to the MCO interviewee.

The MCO representative cited in particular the work Envision has done in helping practices obtain PCMH recognition, which renders them eligible for enhanced payment in

“Envision has been key to the practices trying to obtain PCMH recognition.”

some cases. Envision and the New Mexico Pediatric Society are leading an effort to standardize PCMH requirements for the state. The Medicaid MCOs and the Medicaid Bureau Chief for Quality also are actively involved in the

process. Attaining PCMH designation is seen as vital to being able to operate in the evolving QI environment, discussed further below.

Medicaid Reform in New Mexico: Centennial Care

A major driving force for QI in New Mexico is the state's Medicaid modernization initiative, known as Centennial Care. The initiative aims to create an integrated health service delivery system with a focus on improving quality and reducing cost. After a more than two-year-long planning period, New Mexico was officially awarded a Medicaid 1115 waiver from CMS for Centennial Care in July 2013. The overarching goal of the program, which launched on January 1, 2014, is to transform, strengthen and streamline the Medicaid delivery system, rendering the program better prepared to absorb the additional new members resulting from Medicaid expansion under the ACA. The key building blocks of the new program are shown in the box below.

Key Features of Centennial Care

- Care coordination
- Use of *promotoras* to increase health literacy
- Prevention
- Patient-centered medical homes
- Payment reforms to reward cost effective, "best practice" care
- Greater use of technology to bring healthcare to rural and frontier sites
- Encouraging more engagement in personal health decisions¹

Managed care has been the primary Medicaid service delivery system in New Mexico for more than a decade. The Centennial Care program consolidated the managed care delivery system, reduced the number of managed care plans and made them responsible for both primary care and behavioral health (previously there were separate behavioral health managed care plans.) Medicaid beneficiaries are

required to be in one of the managed care plans under Centennial Care. With the implementation of the ACA, individuals insured through the Insurance Exchange Marketplace also will be enrolled in managed care plans.

Managed Care Plans are Key to Quality Improvement

Prior to Medicaid reform, managed care plans managed the dollars they receive through capitation, established networks of physicians and made timely claims payments. Under the newly instituted Centennial Care, the plans will continue to do so, but will also manage care and deliver outcomes that can be measured in terms of a healthier plan population. To assist managed care plans as they

HEDIS Measures

- ER utilization
- Ambulatory care utilization
- Well Child visits in the first 15 months of life
- Childhood immunizations
- Use of appropriate asthma medications
- Breast cancer screening
- Comprehensive diabetes care
- Timeliness of prenatal and postpartum care
- Frequency of ongoing prenatal care¹

take on a key role in quality improvement, the New Mexico Human Services Department, which operates Centennial Care, is emphasizing specific Health Effectiveness Data and Information Set (HEDIS) outcome measures (see box). The measures have been incorporated into the contracts with managed care plans.

The new Centennial Care program also features payment incentives for health plans and providers to reward them for achieving health outcomes for their patients. The state plans

to focus on developing metrics that represent best practices in two specific areas: treatment of adults with diabetes and of children with asthma.^v

In order to drive the systems change that Centennial Care strives to achieve, managed care plans will have to think and behave differently and support the movement toward care integration and payment reform. Managed care plans have a variety of strategies for improving care within practices and for their beneficiaries. These strategies include, in the case of one MCO, working with Envision. While the Medicaid program has its own contract with Envision NM to improve quality, most of the effort and funding for QI in New Mexico rests with the managed care plans. This critical QI role for managed care plans was confirmed during our interview with the state Medicaid representative.

The managed care plans are currently concentrating on improving quality and reducing costs of those chronic conditions most costly to the new Centennial Care program. This emphasis on the most costly diseases results in the plans focusing predominantly on adults and such chronic diseases as diabetes and heart conditions. Envision NM has a QI package related to childhood asthma treatment, but it recently developed a QI program for diabetes in response to this emphasis.

When asked to describe the MCO's approach to QI, the representative explained that they seek to improve care by offering incentive programs or pay for performance. There also are incentives for attaining PCMH status, in line with the emphasis in the ACA and other programs that this care delivery arrangement is most advantageous for promoting quality. The MCO representative explained that if the managed care organization does not meet Centennial Care's quality measures for their population "there is a significant penalty." The plan representative said that they have initiatives focused on improving specific measures, such as adherence to asthma medication. In addition, the MCO sends out provider engagement teams to educate practices about quality improvement.

The MCO representative explained that while the plan emphasizes care for adults with chronic conditions, it also focuses on improving care for children, and works with Envision, focusing on Centennial Care's HEDIS measures discussed above. The interviewee spoke to the need, over and above working on specific outcomes, of "giving the providers the skill set to make the changes needed to care delivery" and of working with Envision to do so.

Practices and physicians need a "totally different thought process, a totally different way of practicing" in the evolving QI environment, stressed the MCO representative, who noted that some of their physicians and practices are still waiting for patients to come in, for example, rather than proactively managing their care. Again, this MCO is working with Envision to help pediatric practices make this fundamental practice transition.

Evolving QI Infrastructure in New Mexico

Efforts at the state level to create a quality improvement framework have centered on the use of incentives in the new Centennial Care program. The actual impact of these efforts had yet to be realized, however, at the time of our interviews. Representatives of Envision and the physician practices described the evolving QI environment during our

interviews. Currently, this environment is marked by a notable lack of robust QI push from the state or strong pull from the MCOs.

Impetus for QI: Envision New Mexico's Perspective

Envision New Mexico representatives described the disconnect that currently exists in the state around QI: although Centennial Care is intended to be the vehicle for QI at the state level, in reality QI guidance from the state is relatively weak, at least as it relates to pediatric care. "Nobody drives improvement, so I feel like a lot comes from us. There is very little direction from the state to the practices," one Envision interviewee observed. For example, while there is an emphasis on the transition to PCMH, the state has yet to decide on a standard approach to PCMH and the guidance is mixed. The interviewee acknowledged that overall, Medicaid should be the "driver for determining where the focus should be in quality," but currently that is not the case.

Envision does have a collaborative relationship with the Department of Health (DOH) to work on QI with SBHCs; as the Envision representative described the process: "we talk about what the needs are and we create programs to fill the needs." Although the DOH is driving QI in the context of SBHCs, they take a hands-off approach to improvement for general pediatric issues.

In terms of working with MCOs, Envision staff pointed out that other than the one MCO that is focused on quality, "the others don't seem to care too much" about encouraging QI—at least "not enough to work with us directly."

Impetus for QI: Physician Practice Perspective

The providers we interviewed also spoke to the absence of a strong force driving QI in the state. Physician practices felt very little impetus from MCOs to improve quality. Providers reported that MCOs did not pay for improvement on quality metrics or for care coordination or other practice changes that might improve care; as one practitioner stated, "There is no payment for quality yet." This practitioner reported very little interaction with MCOs, noting, "They definitely are not communicating with us. They are not coming into the practices and saying 'we want you to do some quality work. This is your incentive.'" Further, providers report that there is no communication around performance measures related to children in the practice or in the plan. While the MCOs do chart reviews, they do not share the outcomes of those reviews with the physicians. As one practice member described the one-way process: MCOs "come in and look at our charts, but I don't know what happens after that."

Providers also report that the plan does not tell them which pediatric patients are in their panel, at least according to the MCO record: "panel size, a list of panel patients, no, I don't get any of that" from MCOs, according to one provider. Instead, providers in both practices said that they determine who their patients are through other means, such as asking the patients or deciding that they are the primary care provider for children for whom they have done well child checks. Thus, in the current environment, MCOs are exerting little or no pressure on practices to improve quality. Given this absence of external impetus, the drive for quality comes from within the practices themselves. Such internal motivation is essential for practices to improve.

Looking Ahead: QI Challenges and Opportunities for Envision New Mexico

The evolving QI environment offers challenges and opportunities for Envision New Mexico. A major challenge for an organization such as Envision, which is focused on improving the quality of care for children and adolescents, is that the current QI focus is on adults with chronic conditions as they represent a significant source of cost savings. Key informants identified other challenges such as the significant shortage of primary care providers in the state. Indeed, the Health Resources and Services Administration (HRSA) designated 32 out of 33 counties in New Mexico as Health Professional Shortage Areas or Medically Underserved Areas.^{vi} This leaves existing providers with little time to focus on QI efforts, particularly with the influx of more patients into the system as a result of Medicaid expansion under the ACA.

Another challenge to QI identified by respondents is what one referred to as “a general lack of understanding about what is happening in health care” and QI in particular within practices in New Mexico. As one Envision staff member related, when speaking to practices about QI opportunities, she couches the QI effort in terms of managing change rather than focusing on HEDIS measures, which she said often leads to the practices “getting really overwhelmed.” Indeed, many practices in the state do not have a strong sense of how to approach QI and are unfamiliar with the PDSA cycle. Envision is well positioned to work with such practices to provide assistance getting started on QI initiatives; the strength of the IP is that “we’re the only game in town...we have fairly deep roots in the communities. We’ve worked with a lot of these organizations. People definitely turn to us” explained an Envision interviewee.

The newly transformed Medicaid system offers opportunities for Envision New Mexico to provide QI expertise to MCOs and practices working within the evolving framework of incentives and quality measures. As one Envision staff member explained, “potentially it is a real opportunity for us because there will be some changes to payment, and quality will begin to drive things.” Some MCOs have their own QI teams and these have done a lot of work in practices that they own, but struggle with the practices that they do not own. It is here that Envision sees a role for its QI expertise: “That is where they could use us” noted the Envision representative.

Other key informants interviewed also believe that the need for the go-between role Envision NM is playing will increase with the full implementation of the transformed Medicaid system. Although larger practices may have the infrastructure for new financing models such as pay- for-performance or value-based purchasing, smaller practices will not. As the interviewee noted: These payment reforms are “coming down the pike for all practices whether they are ready for it or not.” The interviewee further noted that shifting from a focus on paying for volume to paying for outcomes requires a whole new mind set from the practices and that Envision is instrumental in working with the practices to make the transition.

Indeed, many practices, particularly smaller practices, may not know how to function in this new world and may need assistance in developing ways to “approach determining where they stand with quality outcomes and how to improve their performance,” in the

words of the MCO representative. Again, MCOs could look to Envision to serve as the “go-between for the practices” and help them not only with quality improvement, but also to understand the new QI framework. The MCO representative saw a definite role for

“Federal and state government are becoming more interested in outcomes rather than volume of services ...[as a MCO], our partnership with Envision is improving the outcomes and you can’t do that without the education.”

Envision helping to “get the practices ready to be successful” in the new evolving payment and practice environment.

Once a process of payment for quality in New Mexico is fully implemented and MCOs begin to pay for outcomes, the need for QI expertise will increase and generate heightened demand for Envision NM’s

services. As one interviewee pointed out “other practices would utilize Envision more to help coach them through quality improvement.”

At this early stage in the evolution of the new Centennial Care program, it remains to be seen precisely how the key players—MCOs, physician practices and the state—will work together to promote and support the development of a strong QI infrastructure within the state. Envision NM can build on its strong roots within the community and solid track record as a neutral intermediary to bring these groups together to devise a collaborative approach to advancing QI for pediatric services in New Mexico.

IV. Oregon Case Study

Oregon Pediatric Improvement Partnership (OPIP)

OPIP is a public/private partnership formed in 2010 and is housed within the Oregon Health and Science University's Department of Pediatrics. OPIP's extensive organizational structure includes a Steering Committee and a Partners Committee (see Table 2 for summary overview of OPIP).

QI Initiatives

Over the course of the past several years, OPIP has been involved in four main projects, including two CHIPRA grant-funded initiatives described below. Through its QI efforts, OPIP worked with a total of 26 front-line practices and nine health systems. In its role as the External Quality Review Organization (EQRO)-like to the Assuring Better Child Health and Development (ABCD) III Project, OPIP facilitated a Learning Collaborative of 8 Medicaid Managed Care Organizations that cover one in three children in Oregon. OPIP also has a subcontract to serve as one of several technical assistance providers for the Patient-Centered Primary Care Institute, a public-private partnership. In addition to its project portfolio, OPIP also participates in state-led workgroups and committees that support health transformation efforts through the state. OPIP also develops policy briefs and strategic memos on a range of issues.

Interviews with OPIP staff offered insights into their collaborative approach to facilitating quality improvement activities, which has been to establish a “shared table” bringing together partners and stakeholders. This has created “synergy across the public/private sector around quality measurement and improvement activities,” as one OPIP staff member characterized the work of the IP.

CHIPRA Grant

OPIP is a lead partner in the Tri-State Children's Health Improvement Consortium (T-CHIC), which is an alliance between the Medicaid/CHIP programs of Alaska, Oregon and West Virginia. CMS awarded the consortium a five-year, \$11-million CHIPRA Quality Demonstration Grant in February 2010. OPIP serves a leadership role in facilitating a Learning Collaborative across the three states, and develops and implements the Learning Curriculum. In addition, OPIP consults on and provides technical assistance to T-CHIC on implementing core measures. Moreover, OPIP designed the Medical Home Office Report Tool (MHORT), the process for using the tool, and ways to analyze and report MHORT data.

One portion of the T-CHIC project specific to Oregon is the Enhancing Child Health in Oregon (ECHO) learning community. In partnership with the Oregon Rural Practice Based Research Network (ORPRN), OPIP worked with eight practices across the state to examine how practice characteristics influence the implementation of medical home concepts in pediatric primary care settings. Outcome measures related to OPIP's ECHO practice improvement efforts are found in Appendix B.

Table 2. OPIP Summary Overview as of October 2013

Institutional Home/Year Established	Oregon Health & Science University, Department of Pediatrics/2010	
Mission Statement	<p>OPIP is a public/private partnership dedicated to building health and improving outcomes for children and youth by:</p> <ul style="list-style-type: none"> ▪ Collaborating in quality measurement and improvement activities ▪ Supporting evidence-guided quality activities in clinical practices ▪ Incorporating the patient and family voice into quality efforts ▪ Informing policies that support optimal health and development for all children and youth 	
OPIP Steering Committee	<p>Oregon Health Authority—Office of Health Analytics Oregon Health Authority –Child Health Director Oregon Health Authority – Center for Prevention & Health Promotion Children’s Health Alliance/Children’s Health Foundation Oregon Pediatric Society Oregon Center for Children and Youth with Special Health Needs Oregon Health and Science University - Division of General Pediatrics Child Development and Rehabilitation Center Oregon School-Based Health Alliance Front-Line Health Care Providers Patient/Consumer Advocates</p>	
OPIP Partners Committee	<p>*The Partners Committee includes those listed above, plus the following: Oregon Academy of Family Physicians Oregon Health and Science University – Department of Pediatrics Institute on Development & Disability Family and Community Together Oregon Community Health Information Network</p>	
IP Areas of focus	<p>Children with Special Healthcare needs Early Childhood Development Medical Home Quality Improvement</p>	<p>Quality Measurement Community Engagement Inform Policy</p>
OPIP Projects/ # Practices	<p>Assuring Better Child Health and Development (ABCD)- III (November 2010-October 2012)</p>	<p>OPIP works with 8 Medicaid MCOs that cover 1 in 3 children in OR</p>
	<p>Patient-Centered Primary Care Institute Year 1: October 2012- October 2013 Year 2: Expected</p>	<p>OPIP works with 5 pediatric primary practices</p>
	<p>ECHO Medical Home Learning Collaborative (June 2011-June 2014) Collaboration with ORPRN</p>	<p>8 practices total, OPIP provides hands-on facilitation to 5 practices</p>
	<p>Tri-State Children’s Health Improvement Consortium (March 2010-March 2015) alliance of Medicaid/CHIP programs of AK, OR, WV</p>	<p>T-CHIC engages a total of 20 primary care practice participating sites and one health system</p>
Total Number of Practices involved in OPIP	<p>26 front-line practices, which include 16 Pediatric primary care practices, 9 Family Medicine practices, and 1 health system; additionally OPIP worked with 8 Medicaid Managed Care Organizations</p>	
Total IP Funding	\$1,023,146	
Staffing	5.9 FTE	
Key Contact	Colleen Reuland, MS, Executive Director, Email: reulandc@ohsu.edu	

Stakeholders' Perspective

AcademyHealth staff met with stakeholder representatives to discuss quality improvement efforts in the state as well as OPIP's role in QI. We interviewed representatives of a physician practice, and a former Managed Care Organization, which is now a newly reconfigured Coordinated Care Organization (CCO). We also met with staff members of the Oregon Health Authority, including representatives of Medicaid and Public Health.

OPIP's Work with Physician Practices/Practice Response

In response to the increasing emphasis on PCMH as a vehicle for quality improvement, the physician practice we met with determined that the PCMH transition was also necessary in order for the practice to remain competitive, retain their current patients and attract new patients. Practice leadership learned of OPIP's ECHO Medical Home Learning Collaborative, applied, and was selected to participate. The practice's main areas of focus included developing an overall care-coordination capacity as a key step in the process of transitioning to a PCMH, as well as identifying ways to increase their use of developmental screening tools. OPIP's approach involved monthly phone calls and site visits to determine what progress was being made, obstacles the practice was facing and to hold the staff members accountable for actually making changes.

"I really felt the OPIP calls were [beneficial]; you always walked away with two things you could implement or it triggered something else."

In working with the practice to establish an infrastructure for care coordination, OPIP Practice Facilitators helped the practice overcome physicians' initial resistance to developing this new function, which the clinic now considers to be "an essential position in our clinic." OPIP worked to orient the new care coordinators as they learned their new roles, and staff members interviewed pointed out that OPIP's assistance was critical: "Those were all big things that we wouldn't have done on our own" and the support from OPIP that we have received has been major," in the words of one staff member.

Care Coordinators have been at the center of the practice's transformation. As one staff member explained: "...a lot of our change has been spearheaded by care coordinators...in the past when you would spread [changes/improvements] out to other doctors you would have these little silos, but now the care coordinators are the connection pieces between all the groups" in the practice.

Overall, the practice found their participation in the ECHO Learning Collaboration to be highly beneficial and credited OPIP with their progress toward achieving PCMH designation from the state. Staff members noted that the practice progressed from tier

one to tier three in less than a year with the benefit of OPIP's Practice Facilitation. As one staff member noted: "I mean to make this much of a transformation in a clinic that was at the very rock bottom" is impressive. The practice is currently planning to apply for NCQA medical home designation.

Oregon Health Authority (OHA) Perspective

In discussing the role of OPIP in QI initiatives in Oregon, one OHA interviewee observed that OPIP’s pivotal role became clear to him when he worked in states that did not have an IP. He described the absence of an IP as a “vacuum” and a “considerable deficit” in such states.

“...to do some of the translation of public policy to practice-level transformation with the specific focus on children’s health” – as has been done in Oregon – would be “almost beyond the realm of possibility...without having an improvement partnership actually on the ground operating and functional.”

OHA representatives described OPIP’s role in facilitating QI efforts and initiatives by serving as a bridge between state-level agencies such as Medicaid

and physician practices. One interviewee remarked that OPIP has created “bridges outside of the clinic wall.” Another state representative noted that the policy action is happening at the “intersection between our state Medicaid agencies and the CCOs.” The improvements needed to meet quality metrics must happen within practices, indicated the interviewee, and “I really think it’s critical to have OPIP here.”

“[OPIP] has “done a tremendous job in educating practices and pulling them along, helping them to understand that these kids [with special health care needs] require a different level and quantity of care.”

Key informants detailed OPIP’s strengths in distilling key lessons learned, and translating best practices, noting that this is critical to the sustainability of quality improvements. OPIP has “very high standards” and “wants you to think about policy implications, articulate what those are and the methods for sustaining change over the long-term.” OPIP, as one state

“OPIP has really taken the role in being a facilitator and teacher around quality improvement for practices trying to achieve certain levels with PCPCH.”

representative pointed out, goes “through the cathartic process of distillation of learnings.” Having an organization such as OPIP in this role is key, according to this interviewee, in that the “translational stuff is not going to happen through the state or federal government. It has to have a different venue for it to really gain traction.”

Beyond its involvement in QI initiatives, OPIP participates in policy discussions at the state level. OPIP has provided “a reality check for the state” in the words of one OHA interviewee, holding the state’s feet to the fire and reminding the state of work to be done in specific areas of pediatric policy within Medicaid transformation efforts. OPIP “constantly reminds [the state] of the population that may be systematically underserved”

noted the respondent. The state values, according to this interviewee, the ways in which OPIP is an active and informed participant in policy discussions, understanding the “details [and] technical complexities” and

OPIP “has the reputation for being the area content expert in [Pediatric QI]...they produce a set of very thoughtful recommendations and you know it’s coming from that depth of expertise; it may carry a different weight than some other recommendations.”

“actually [adding] to the conversation.” According to one interviewee, this level of knowledge and engagement sets OPIP apart from other community partners in the state that do not have a comparable “depth and breadth” as OPIP.

Medicaid Reform in Oregon: Creation of Coordinated Care Organizations

OPIP operates in the context of a state that has been at the leading edge of health care reform efforts for more than two decades. Recent changes have involved a concerted effort to transform a fragmented Medicaid system of siloed services into one coordinated, integrated system of care. The new integrated system replaces one in which managed care organizations provided care to the majority of Medicaid beneficiaries on a capitated basis, and mental health organizations and dental care organizations provided services separately. This fragmented system proved too costly to support as Medicaid expenditures ballooned to one of the largest items in the state budget.^{vii}

CMS granted the state an 1115 Medicaid Demonstration waiver in July 2012, and shortly thereafter, the state divided its Medicaid program into 16 regions, and assigned each region a Coordinated Care Organization (CCO). CCOs are responsible for the full range of health services including physical, behavioral, and eventually dental, for their members. More than 90 percent of Medicaid and CHIP members have been automatically transferred into a CCO and their affiliated health plan.^{viii} The 16 CCOs are essentially networks of providers that are given a global budget and bear the financial risk for the care of their patients, while ensuring that they meet certain quality metrics. Specifically, the federal waiver requires that the CCOs make progress on 33 quality and access measures. Of the 33 measures, 17 are identified as incentive measures because they are linked to valuable bonus payments. More than half of the incentive measures affect pediatric care either directly or indirectly (see Table 3).

Evolving QI Framework

A new framework for quality improvement has evolved out of the ambitious redesign of the state’s Medicaid program, with significant implications for QI and the organizations involved. First, the transformation of the OHP has put the Oregon Health Authority in the position of driving the overall QI agenda through the framework of the new incentive measures. Under the new system, OHA collects data from CCOs on a regular basis and disburses incentive funds if benchmarks are met.

Second, there is an evolving shift in the role of providers in terms of the impetus and accountability for QI. As one CCO representative described the transition: “...what we’re moving away from is this idea that the payers should control quality, that the payers are the stewards of quality care. That doesn’t feel right to anybody anymore. What feels right is that the providers who are delivering the care should be accountable for the quality that they are delivering and they should be accountable to themselves and to their patients.” The CCOs, for their part, have an oversight role, monitoring and supporting physicians’ adherence to QI. The CCO representative described this role in the following manner: “Our entire staff thinks of our job as quality improvement... all of us focus exclusively on how we are doing in a certain area.” Another interviewee explained that prior to the formation of CCOs, the MCOs “were variable in terms of how they actually did quality

improvement.” The CCOs now have incentive metrics on which to focus and guide their QI efforts

Table 3. CCO Incentive Measures and 2014 Benchmarks

Measure	2014 Benchmark
Alcohol or other substance misuse, screening, brief intervention and referral to treatment (SBIRT)	13 percent
Follow-up care for children prescribed ADHD medication	51 percent
Follow-up after hospitalization for mental illness	68.8 percent
Screening for clinical depression and follow-up plan	N/A Reporting only for year one
Mental and physical health assessment for children in DHS custody	90 percent
Timeliness of pre-natal care	90 percent
Elective early delivery (before 39 weeks)	5 percent or below
Developmental screening (by 36 months)	50 percent
Adolescent well-care visits	57.6 percent
Colorectal cancer screening	TBD
Controlling high blood pressure	N/A Reporting only for year one
Diabetes: HbA1c poor control	N/A Reporting only for year one
Total Emergency Department and ambulatory care utilization	44.6/1,000 member months
Patient-centered Primary Care Home (PCPCH) enrollment	Goal: 100 percent of members enrolled in Tier 3 PCPCH
Access to care (CAHPS composite)	88 percent
Satisfaction with health plan customer service (CAHPS composite)	89 percent
HER adoption (Meaningful Use composite)	72 percent

Sources: Oregon Health Authority. *CCO Metrics Brief*, February 2013 and *2014 Incentive Measure Benchmarks*, January 13, 2014 available at <http://www.oregon.gov/oha/>

Working with OPIP: Coordinated Care Organization (CCO) Perspective

We met with representatives of one of the newly formed CCOs. The interviewee provided an example of how OPIP worked with payer and provider groups to develop systems changes to ensure developmental screening was being performed accurately, followed up appropriately, and billed correctly, and that there was a process in place to ensure feedback to providers. To provide context, the interviewee shared that the CCO had been working with OPIP to convince providers that “it’s worthwhile to do a very intentional screening instead of just an eyeball-type screening, and then when you do it, how to build systems that code for it.” OPIP was instrumental in working with health plans, according to the interviewee, ensuring that coding for such screening is done automatically. OPIP identified the barriers and went beyond what the CCO is requiring “in the sense that what we just want to see is that the screening was done and that it was billed for

“CCOs tell the providers that developmental screening is ‘one of the metrics tied to money and if you can show us performance on this metric, we’re going to give you a lot of bonus dollars.’ Now there is buy-in from the provider to do this that never would have been had we not had OPIP doing the groundwork.”

accurately” explained the CCO representative. OPIP focused on whether a referral was made for early intervention services if the screening was positive, and whether the provider received a follow-up on that referral. The interviewee noted that without feedback that the screening is making an impact on the patient’s care, providers do not see “why they should care about developmental screening or bill for it.” The CCO representative highlighted OPIP’s key role in laying the foundation for this systems-level change.

Looking Ahead: QI Challenges and Opportunities for OPIP

The newly transformed Medicaid landscape in Oregon continues to evolve and offers both challenges and opportunities for OPIP. The challenge for an IP such as OPIP, which is focused on improving children’s and adolescent and health care, is that the cost-saving focus at the center of the transformed system puts a higher priority on efforts to improve care of the most expensive patients, where there is a greater chance of wringing savings from quality enhancements. These high-cost patients tend to be adults suffering from costly chronic conditions. CCOs, for their part are under pressure to demonstrate results in terms of improved quality and many of the incentive funds are tied to adult measures.

OPIP has the opportunity to work with the newly formed CCOs to implement systems-level changes to meet the established benchmarks and receive incentive payments. Some CCOs, for example, may need to implement changes such as developing registries to improve population health monitoring or new processes for claims submission to ensure that services provided are being accurately recorded.^{ix}

In discussing QI efforts, the CCO representative we interviewed described the organization’s internal QI teams that are deployed to work with practices and physicians to improve certain measures. In considering whether to bring in an external QI group such as OPIP to work with physician practices, the interviewee noted that “OPIP has the resources, the knowledge, the experience to really move quickly” and identify key problems and how to address them. On the other hand, the interviewee noted that there are advantages to having an internal QI focus and experience in which provider groups are encouraged to come together “around what’s working well and what is not working well and to solve their own problems and be accountable for the results.” Such internally motivated QI creates a different dynamic and level of accountability, according to the interviewee.

The CCO representative did see a key role for an external QI group such as OPIP, however, describing the dynamic as a “pull rather than a push” to bring in OPIP in to work with the practices. The interviewee noted out that there are times, for example, when practices need help on a certain metric and do not know how to address the problem. The CCO could then ask the practice: “Would you be interested in having OPIP come in and work with you?” This creates a situation in which practices pull in OPIP for assistance rather than OPIP pushing the practices to work with them. OPIP will build on its experience assisting practices to transition to PCMHs and will continue its work as one of the technical assistance providers in the Patient-Centered Primary Care Institute. OPIP is also focused on collaborating with OHA and its new

Transformation Center to create synergy at the practice level to ensure that CCO metrics goals are met.

One interviewee suggested that while the larger CCOs may have a significant internal QI capacity, there is a role for IPs to work with smaller CCOs that are beginning to approach QI; as one interviewee phrased it: “how to facilitate change, how do we manage that, how do we set performance targets, how do we do metrics, how do we do data collection, how do we design all that infrastructure in those pieces.” The interviewee went on to point out “one of the opportunities for IPs is to think beyond the tri-county area to what we can do in the rural communities to affect change.”

Other potential opportunities for OPIP include working with CCOs as they prioritize partnerships between mental health and physical health organizations—both in terms of payment and how the care is delivered. As one interviewee explained, CCOs work with community organizations, public health, and home visiting organizations, and emphasized: “we have a much broader reach than just this strict health care system of clinic and hospitals.” Based on its experience bringing partners together, OPIP would likely play a valuable role within this integrated care system.

V. Opportunities and Challenges in Advancing QI at the State Level

This case study report illustrates the pivotal role played by Envision and OPIP in state-level QI efforts to improve primary care for children and adolescents. These state-level IPs apply QI science and systems-based approaches to improve the quality of care, since “Real improvement comes from changing systems, not changing within systems.”^x Improvement Science, like most science, continues to evolve, however, as do approaches to advance QI for pediatric populations.

Individuals interviewed for this case study widely acknowledged that IPs play multiple roles in their states, encouraging and supporting QI through coaching and training, practice facilitation, and serving as intermediaries between physicians, managed care organizations and state Medicaid agencies. Beyond their QI role, IPs also are working on broader issues such as preparing practices to operate within the evolving Medicaid quality incentive framework in New Mexico and Oregon, as well as assuming a role in policy discussions in Oregon.

The two IPs examined in this case study operate in a similar environment. Both states’ Medicaid programs have very recently undergone significant transformations that reserve reforms key roles for MCOs in New Mexico and CCOs in Oregon. These organizations are guided by the “pull” of incentives at the heart of their states’ transformed Medicaid systems. Medicaid reforms position MCOs and CCOs to control the funding levers to financially reward plans meeting quality measures. These changes provide the IPs with both opportunities and challenges to provide the on-the-ground “push” to support and advance QI at the state level.

The evolving QI environments in New Mexico and Oregon, with their attendant focus on specific incentive measures, allow Envision and OPIP to build on and showcase the depth and breadth of their experience. Indeed, as evidenced by our interviews with key informants, Envision and OPIP are held in high regard by the practices they work with, and are sought out for their QI expertise and their neutrality. The heightened focus on advancing QI through the development of a robust care coordination capacity within practices as well as the ongoing transformation of practices to PCMHs will work to the advantage of IPs such as Envision and OPIP, which have significant experience supporting such changes.

MCOs are increasingly interested in bringing about improvements that are plan-wide or extend across their entire Medicaid patient population. In order to advance these large-scale improvement efforts, IPs will need to expand the focus of their QI efforts from a limited group of practices to an MCO’s entire patient panel.

The prevailing focus on value and quality within the transformed Medicaid systems in which IPs function underscores the importance of ensuring that appropriate data are readily available to demonstrate the return on investment of QI efforts in ways that policymakers, legislators, MCO executives and others find compelling. Such data needs

to reflect key factors such as the cost of QI initiatives (in terms of staff time and resources devoted to the effort) as well as the level of improvement achieved. Cost savings resulting from the specific QI intervention are of interest, but generally beyond the scope of a typical IP project.

IPs have significant experience working with managed care plans and providers to collect and analyze quality improvement data critical to demonstrating the link between investment in QI and improved outcomes. This experience puts IPs in a strong position to take a leadership role in such efforts at the state level.

In addition to the many opportunities for IPs that are emerging from the changing QI landscape, IPs face two main challenges going forward. First, the QI focus is currently on the most expensive conditions such as diabetes, which offer opportunities for the greatest cost savings. Such a focus on costly adult chronic conditions shifts the attention away from pediatric health care issues. However, IPs are consequently faced with the challenge of keeping the spotlight on pediatric QI and on services such as health promotion, disease prevention, preventive screening and health supervision. IPs need to highlight the link between improving the quality of these services and improving health outcomes as that will demonstrate clearly how early detection and treatment of health conditions in children and adolescents saves Medicaid, health insurers and managed care plans—and the overall health care system—resources over the long term. This is especially true when an entire family's health issues are addressed, such as smoking and obesity prevention. IPs may need to point out that addressing obesity, for example, in children and youth could lead to a reduction in adult diabetes and its attendant costs.

Second, IPs face heightened competition in the world of QI experts and technical assistance providers. Some MCOs and CCOs already have their own internal QI teams or departments while others are working to develop such internal capabilities. In addition, universities and other organizations are entering the QI arena. It will be a challenge for IPs to identify their specific niche in order to compete against these new entrants to the field of QI promotion. However, NIPN offers a unique role. NIPN brings together insurers, providers, families, public health, and Medicaid to the table. It becomes an honest broker among the parties. More often, NIPN can provide the answer to these parties' questions or issues.

IP efforts to work with broader patient populations as well as across multiple states will require additional financial and administrative support. As a result, IPs such as OPIP and Envision appreciate the value of an umbrella organization such as NIPN. These IPs are looking to NIPN to provide continued support of their QI efforts at the state level, while hoping to see NIPN broaden its reach and presence on the national level. These issues are discussed in the final chapter of this case study report.

VI. The Value of NIPN to State IPs and Recommended Next Steps

Value of NIPN

Key informants involved in IP initiatives in both New Mexico and Oregon expressed great appreciation and enthusiasm for NIPN. Those interviewed underscored the value to them of a national network for state-level IPs in general, as well as the specific assistance and leadership NIPN has provided to them in their efforts to improve the quality of health care for children and adolescents in their respective states. NIPN has worked to support state-level IPs as they have developed public-private partnerships and created a “common table” for QI in their states. One respondent expressed the core value of NIPN in the following way: “NIPN is all about building infrastructure at the state level.” NIPN achieves this, in the view of this respondent, by expanding the understanding of innovative approaches to QI initiatives among IPs, building an effective, streamlined infrastructure that leads to enhanced internal capacity for QI at the state level. One respondent contrasted NIPN’s work with that of an organization that comes into the state, conducts a project and leaves without developing any sustainable capacity on the ground to continue the QI work after the project ends. NIPN adds value to existing systems in a way that other organizations do not.

“NIPN is all about building infrastructure at the state level.”

Key informants cited such steps as bringing experts in to offer assistance to their IP as one of the core benefits. More than the specific activities, however, key informants value the

fact that NIPN structures the assistance in such a way as to build infrastructure at the local level. One of the respondents had served as one of the experts, advising on how to structure the coaching. This respondent believed that these presentations were good for the network, in that they help newer IP members get up to speed.

Respondents also cited the value of the weekly telephone calls. A respondent said that not only is the advice useful, but realizing that other people are experiencing the same things is helpful. One key informant noted that during the calls she often felt relieved to learn “it is not just me” having questions or difficulty.

Finally, key informants found value in the work being done to build the infrastructure of the network as a whole. Specifically, respondents appreciate the recent work to develop core measures for asthma, which would be available for all sites to use. Having these common measures ensures comparability across sites in terms of outcomes and also means that individual IPs do not have to devote limited time and resources to developing their own measures.

NIPN’s Overarching Role as Learning Collaborative

NIPN serves an important and valuable role as an active learning community for state-level IPs. Key informants interviewed spoke highly of the dynamic mentor and advisor role that NIPN serves, affording IPs valuable opportunities to network and collaborate. In this way, NIPN provides a window onto a larger world of quality improvement initiatives and funding opportunities. Interviewees noted that NIPN is instrumental in

knowledge management, information sharing and cross-fertilization of ideas and experiences on multiple levels, across a range of areas (see box).

NIPN advances this knowledge sharing through regular coaching calls, maintaining an electronic mailing list (Listserv) that allows members to share ideas and challenges, and conducting trainings that enable IPs to learn from others' experiences. Indeed, interviewees described the important role NIPN serves in providing access to their colleagues across the country working on similar issues and facing similar challenges within their own states. As one interviewee noted, this learning network is critical given that "in quality improvement, specialists are few and far between." Another respondent who pointed to the value of learning what others are doing echoed this

NIPN Support for QI Knowledge Sharing

- Identification of partners, development of community partnerships
- Management and operation of an improvement partnership
- Navigating relationships with steering committee members and other partners
- Identifying funding opportunities; developing relationships with funders
- Advice on how to manage the project "politics" that impact improvement efforts
- Connecting IPs with other IPs that have specific expertise (measures development, relationship with SBHCs, etc.)
- Advice and information on specific improvement topics and projects
- Assistance in building QI infrastructure at the state level to ensure sustainability of QI initiatives and efforts

sentiment, describing how it is easy to feel "isolated" working in a small department in a small state. As this individual expressed it: "seeing what is being done on different levels with people who have a different approach to things is beneficial."

One interviewee framed the value of NIPN in terms of intellectual sharing: "I find value in [Name]'s brain." In a similar vein, another respondent also spoke to the value in NIPN's expertise, noting: "I find [Name] to be really, really, thoughtful smart...really practical like boots on the ground kind of stuff and I appreciate her perspective on this work." Another respondent noted [Name]'s strength in "figuring out the match" in terms of which states are strong in specific issue areas and directs those with challenges to tap into a particular state IP's area of expertise. Another key informant shared that she learned about the CHIPRA grant through NIPN. The interviewee explained that her

NIPN fills the QI knowledge gap at the state level, as one interviewee explained: "I have people I can call when I'm in a bind about something or trying to figure something out. I don't have those colleagues in my state." The respondent added that "NIPN has been tremendously important for my personal growth and development" as well as for the development of the IP.

relationship with NIPN not only enabled her to learn about that particular funding opportunity, but the training and technical assistance that NIPN provides gave her the confidence to pursue that opportunity.

Finding Value in Trainings, Meetings and Data

Key informants also found value in the NIPN training opportunities, and the fact that (training was based on the IHI Collaborative model for achieving quality improvement. I found it helpful to do the case studies where you were presented with a realistic problem...something the practices were facing and then bringing it back to a larger group of QI specialists and facilitators and having them pose different approaches to the problem. NIPN started to use that layout as well and I think that's been helpful" explained one interviewee.

One respondent emphasized the importance of the annual operations training meetings, noting "I always feel like I gained something by going to those annual meetings. I learned something new about how someone does their asthma project...those mediums have been really valuable to me personally. "

Respondents also expressed appreciation for NIPN's work in developing core measures. They found these efforts particularly valuable in saving each individual IP from having to dedicate limited time and resources to developing their own measures. Beyond the development of core measures, NIPN helps IPs to work with practices to understand how to actually use data to improve care (not merely collecting data, but how to analyze the data to make effective quality improvements in specific areas).

Recommendations for Strengthening NIPN/Next Steps

Key informants interviewed about their experience with NIPN were asked to suggest areas for strengthening NIPN as an organization as well as next steps and other issues NIPN might focus on in the future. Interviewees highlighted expanding NIPN's relationship at the national level, developing multi-state, cross-cutting improvement projects, establishing a national QI repository, identifying new areas for QI focus, fine-tuning the coaching calls and providing support for building quality infrastructure at the state level.

NIPN to Expand and Strengthen Relationships on the National Level

Interviewees spoke to the critical role NIPN could play on the national level. One respondent identified parallels with the IP role within the state and framed it this way: "just as we as a state IPs present ourselves to the state health agency and to other partners within the state, I think it is important for NIPN to develop their relationship with federal agencies." A broader role for NIPN would be to seek out funding for continuing and expanding the IP network as well as funding for multi-state projects and other initiatives. Moreover, NIPN could play a critical role in "getting improvement partnerships on the radar at both the federal and state level" in the words of one interviewee. It would be valuable for NIPN, according to another respondent, to be "having conversations that impact national policies, which then trickle down to the state. They would have a key role informing federal partners." Another interviewee seconded this approach and pointed that some of the state-level recognition comes from the federal government saying, "Okay pay attention here."

It was also suggested by key informants that NIPN could position itself to develop consensus around bringing about a heightened focus on pediatric health care quality

improvement on a national level. In this new expanded role, one interviewee explained, NIPN could “develop collaborative aims to improve the immunization rates or reduce the variations that exist around the country”; create alignment and synergy with “the national quality strategy or AMCHP to help bring focus to some issues.” As this respondent pointed out, if NIPN could expand its reach “that could be transformative.” NIPN’s role would be to develop the conceptual framework around such an initiative and be the vehicle for communicating with NCQA, for example about the need for pediatric focus in their medical home model.

By serving in a leadership role interacting with organizations on a national level, NIPN could establish itself as an independent QI-focused organization not tied to a particular state or federal agency. This is critical because of the stigma attached to experiences coming out of specific states: as one respondent explained often the reaction to a specific quality initiative is discounted or dismissed as impractical by others who say “well that was done in [*Name*] state but cannot be done here.” As the respondent explained: “It has to have a different venue for it to really gain traction and take away the stigma of being: well there’s that state again.”

Development of Cross-IP, Multi-State Collaboration

A number of key informants interviewed spoke of the need for a cross-IP, multistate project that would afford them the power of collective impact that a single state-level IP project lacks. As one interviewee noted, such a broader collaboration would open up “the conversation about how public health measures are changed and moved because as individual IPs we don’t have that ability to pave the way that a larger collaboration would have.” In supporting multistate projects, NIPN would continue, strengthen, and enhance collaboration among IPs.

Respondents strongly believe that the next logical step for NIPN is to seek funding to do an improvement project as a network, one that involves multiple states working on the same topic as a network. As one respondent put it: “I think the untapped value of NIPN [is in figuring out] how we can do [improvement work] more efficiently.” Respondents believe that individual IPs could leverage their efforts if they could work together on a similar project as a network, and share experiences to avoid duplication and to make their QI work more efficient.

Key informants interviewed believe that NIPN is poised to become a vehicle for quality improvement for Medicaid in the member states. They cited the recent work establishing core measures for asthma and other conditions as a foundation for conducting improvement work as a network, rather than as individual IPs and felt that core measures work should be expanded. One respondent pointed out: “I think that is a hugely important piece of work. And it needs to be done beyond asthma, for other conditions.” Respondents were clear about cumulative advantages of doing IP projects. In addition to the improvement that results from a given project – for example, in terms of asthma – there is also the fact that each project builds capacity and leaves, at the end of the project, enhanced capability in the state. Respondents stressed the importance of QI funding for the state QI infrastructure, so that capacity is built and enhanced.

A number of respondents stressed the importance of NIPN to work on core measures for other conditions (beyond asthma and obesity). One respondent, taking asthma as an example explained: “You have this measure, which is appropriate use of a controller medication but on the ground, clinically when you’re trying to do QI work, there’s stuff that needs to get done in order for that measure to be meaningful. In other words, if a practice isn’t appropriately documenting severity and control in a patient then the HEDIS measure is kind of meaningless.”

NIPN, for example, could manage a multi-state crosscutting quality improvement project designed to improve care across the Medicaid population in a number of states. NIPN might organize a national quality improvement project focused on asthma for example. Respondents believed that the work on the asthma core measure set, combined with emphasis on childhood asthma in Centennial Care in New Mexico, for example, would make this an ideal first project.

Establishment of a National QI Repository

One interviewee recommended that NIPN could serve as a repository of resources, strategies, tools, and instruments for quality improvement at the national level. Respondents expressed the need for NIPN to focus on other content areas beyond the core measures for asthma and obesity: “to do that in other content areas so that IPs didn’t have to spend a ton of time doing the research about best practices or evidence-based practices.” As one respondent put it, “If there was a clearing house for different topics I think that would be awesome.”

NIPN could serve as the pivotal organization for pulling together “current accepted recommendations, standards, national guidelines” on a range of conditions such as adolescent diabetes and obesity and areas such as developmental screening. This means IPs do not have to “spend a lot of extra time on development of clinical materials.” NIPN could serve a useful role in this respondent’s view, developing and collecting such materials.

Identify new areas for quality improvement focus

Individuals involved in state-level IP efforts identified a number of quality improvement areas in which NIPN may want to focus in the near term:

- *Intersection between education and health system reform:* understanding the relationship between these systems—how they overlap and interact: issues such as pediatric health and the Early Learning System, screening for adverse childhood experiences, Kindergarten readiness; teaching providers how to engage youth using the YEHS instrument
- *Transition from adolescent to adult:* focus on preparing teenagers to be fully functioning adults within the context of taking greater responsibility for their own health care needs (having an insurance card, making doctor’s appointments, filling prescriptions). This transition is particularly difficult for young adults with special health care needs.
- *Provide support to IPs to focus beyond the metropolitan areas within their states:* encourage IPs to approach smaller organizations and practices in rural areas that

do not have experience with QI and that are in need of technical assistance in order to begin to focus on QI initiatives.

Pairing IPs

One respondent raised the issue of NIPN continuing to explore efforts to pair IPs so that they can mentor each other and help with specific issues. Each individual IP has strengths and experiences in different areas. Such pairing is particularly important for new and emerging IPs.

Fine-tuning the coaching calls

Several respondents spoke of the need for fine-tuning the coaching calls so that they meet the needs of IPs that are in different places along the continuum (e.g., new, emerging, young, established) as well meeting the needs of different audiences (Executive Directors, Researchers, Practice Facilitators) with different knowledge backgrounds, needs and expectations. One respondent encouraged NIPN to “keep working on that coaches group.” This respondent, while recognizing the challenges involved, urged NIPN “to not give up on the idea, to pull people together to do the practice facilitation to become a learning group.”

Building quality improvement

A number of interviewees raised the issue of the role that the more mature IPs play in the effort to build and strengthen state-level quality infrastructure. Given that certain IPs are more advanced in terms of their experience with quality improvement efforts—either by virtue of how long the IP has been in existence, or the expertise of its leadership team, or the environment for quality within their state, or all of the above—these IPs play a critical role in mentoring and advising emerging and less experienced IPs. These activities aimed at sharing expertise so that the quality infrastructure may be built in other states is currently handled on a volunteer basis by the more experienced IPs whose leadership and staff are not compensated for the time devoted to this effort. One interviewee remarked: “I’m struggling a bit with the pay-in part because I feel like we don’t have a lot of operational support. We contribute a lot into NIPN...I think it is going to be interesting how to balance that.”

In a similar vein, activities devoted to developing core quality measures (e.g., for asthma, obesity, etc.) are also handled on a volunteer basis by IP leadership. These are time-consuming activities that require not only research of the measures currently in use, but much back and forth telephone and email conversations reacting to and discussing each quality measure to determine precisely which ones should be included among NIPN’s list of recommended measures. These concerns reflect NIPN’s growing pains as a developing organization. With the number of IPs joining its expanding network on the rise, NIPN needs to address such infrastructure building issues.

Prospects for the Future

NIPN has provided vital support for existing and emerging IPs, and in so doing has been instrumental in significantly advancing QI efforts in numerous states during its first five years of existence. As was detailed in this case study report, IPs are involved in crucial initiatives in the two states examined here, with one interviewee noting that to achieve

the level of translation of public policy to practice-level transformation would be “almost impossible” without a functional IP operating in the state.” The role that IPs play in such translational work is unique, as in the words of one key informant: it “is not going to happen through the state or federal government; it has to have a different venue for it to gain traction.” NIPN provides critical support to IPs enabling them to effectively translate policy into QI practice.

NIPN is at a crossroads with many opportunities ahead to build on its efforts to support and advance QI initiatives and strengthen the QI infrastructure within and across states. As highlighted in this last section of the report, IPs look to NIPN to be a major force for QI on a national level in the near future.

Appendix A. Case Study Methodology

The Nationwide Improvement Partnership Network (NIPN), the organizing body for state-level Improvement Partnership (IP) initiatives in more than 20 states, engaged AcademyHealth to evaluate the IP model and the impact of NIPN on state-level IP efforts. Two states were selected for detailed study—New Mexico and Oregon—in an effort to profile best practices, strengths, relationships with key partners and obstacles to implementing quality improvement initiatives. The overarching goal of the evaluation is to provide NIPN with information that fully illustrates the network’s reach and impact, its strengths and challenges, and to identify future actions for NIPN as it continues its support of state-level improvement partnerships.

AcademyHealth researchers first conducted a comprehensive review of materials to familiarize themselves with the content and the context of the two IPs: Envision New Mexico and the Oregon Pediatric Improvement Program (OPIP). Numerous background documents were reviewed, including, among others:

- New Mexico Human Services Department. *Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond*. 2012
- Envision New Mexico website information and background materials
- Coughlin, Teresa, Kevin Lucia and Katie Keith. “ACA Implementation and Tracking: New Mexico Site Visit Report.” The Urban Institute, August 2012.
- OPIP website information, background materials and Annual Report
- Oregon Health Authority website and background materials
- Published articles detailing OHA/Medicaid reform (Washington Post, Modern Healthcare, etc.)
- State Improvement Partnership (IP) Programs: Process Evaluation Results. Academy Health/NIPN.
- Shaw, J.S., Norlin, C., Gillespie R.J., Weissman, M., McGrath, J. The National Improvement Partnership Network: State-Based Partnerships that Improve Primary Care Quality. *Academic Pediatrics*. November-December 2013; 13 (6 Suppl):S84-94.

Parallel with the background document review, discussions were held between the AcademyHealth project team and individuals active in and knowledgeable about quality improvement efforts in New Mexico. Once these discussions and the background document review were completed, a list of key informants was developed. The AcademyHealth Project Director discussed the list of potential key informants with IP executive leadership and other staff members. From these discussions a short list of key informant interviewees was developed, drawing representatives from five distinct categories:

- 1) IP (Envision New Mexico/OPIP)
- 2) Department of Public Health
- 3) State Medicaid Agencies
- 4) Managed Care Organizations
- 5) Health Plan Providers

Key informants were identified within each category to approach and request their participation in semi-structured qualitative interviews. Following the review of background materials AcademyHealth developed semi-structured interview guides tailored to each key informant type.

Interview guides were developed to elicit detailed information about the:

- Interaction between the IP and state-level quality improvement specialists within:
 - Department of Health and Department of Medicaid
 - Managed Care Organizations/Coordinated Care Organizations
 - Physician Practices
- Specific strengths of the IP
- Challenges/barriers to progress faced by the IP
- Ways in which those involved in quality improvement initiatives in use NIPN to assist them in their work
- Recommendations for future directions for NIPN

Data Collection

AcademyHealth team members scheduled face-to-face interviews designed to be between 45 and 60 minutes in duration. These interviews were conducted in New Mexico on October 29, 2013. Due to scheduling conflicts, several key informants were not available for face-to-face interviews. For those individuals, telephone interviews were conducted on December 11 and 16, 2013. A final telephone interview was conducted on January 9, 2014. Face-to-face interviews were conducted in Oregon January 27-31, 2014, with a telephone interview conducted on February 5, 2014. The case study data collection effort is summarized in Table 1 below.

Table 1. Case Study Data Collection: Summary

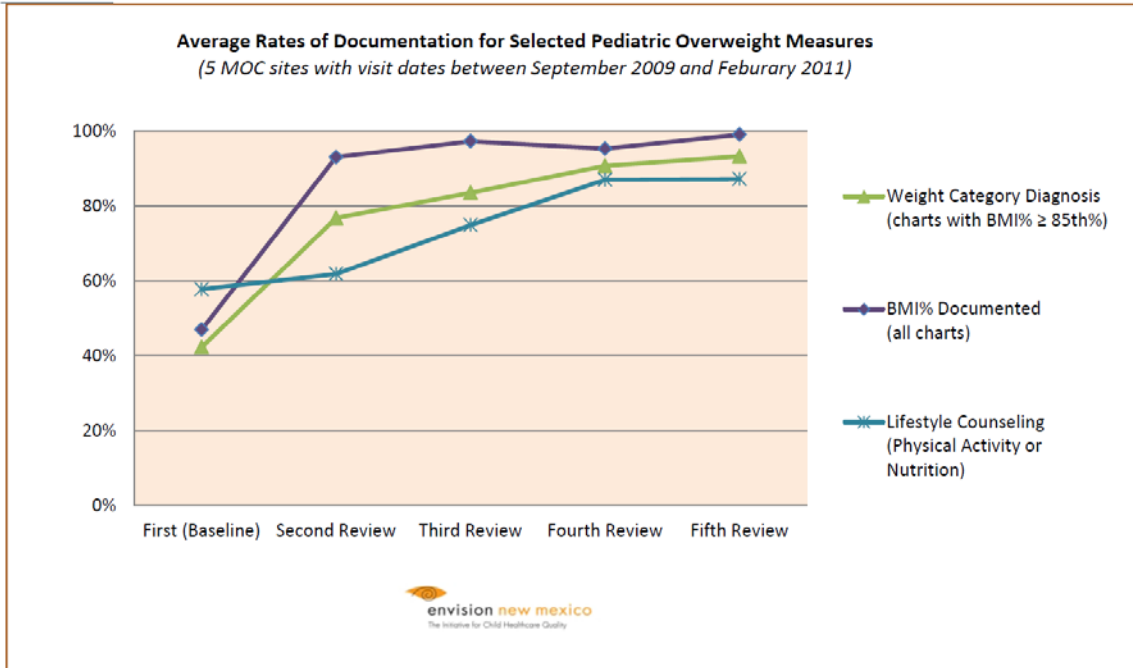
Sample: New Mexico	<p>A total of 11 key informants were interviewed</p> <ul style="list-style-type: none"> ▪ Representatives of organizations involved in Quality Improvement initiatives in New Mexico, including New Mexico Health Services Department, New Mexico Medicaid, Managed Care Organizations, physician practices and Envision New Mexico.
Sample: Oregon	<p>A total of 12 key informants were interviewed</p> <ul style="list-style-type: none"> ▪ Representatives from organizations involved in Quality Improvement initiatives in Oregon, including: Oregon Health Authority, Coordinated Care Organizations, physician practice and the Oregon Pediatric Improvement Partnership (OPIP)
Method	<p>Semi-structured, in-person interviews were conducted</p> <ul style="list-style-type: none"> ▪ Interviews were audio recorded for subsequent transcription ▪ Interviews were of 45 to 60 minutes in duration
Location	<p>Interviews were conducted onsite in agency administrative offices and physician practice sites</p>

The AcademyHealth Project Director conducted the face-to-face key informant interviews. Each interview was recorded by a set of two digital recorders to ensure that the information elicited during the interview was fully and accurately captured. Telephone interviews also were recorded. The digitized recordings were subsequently sent to an independent transcription service. The interview transcripts formed the basis for the qualitative findings of the key informant interviews presented in the New Mexico and Oregon chapters of this case study report.

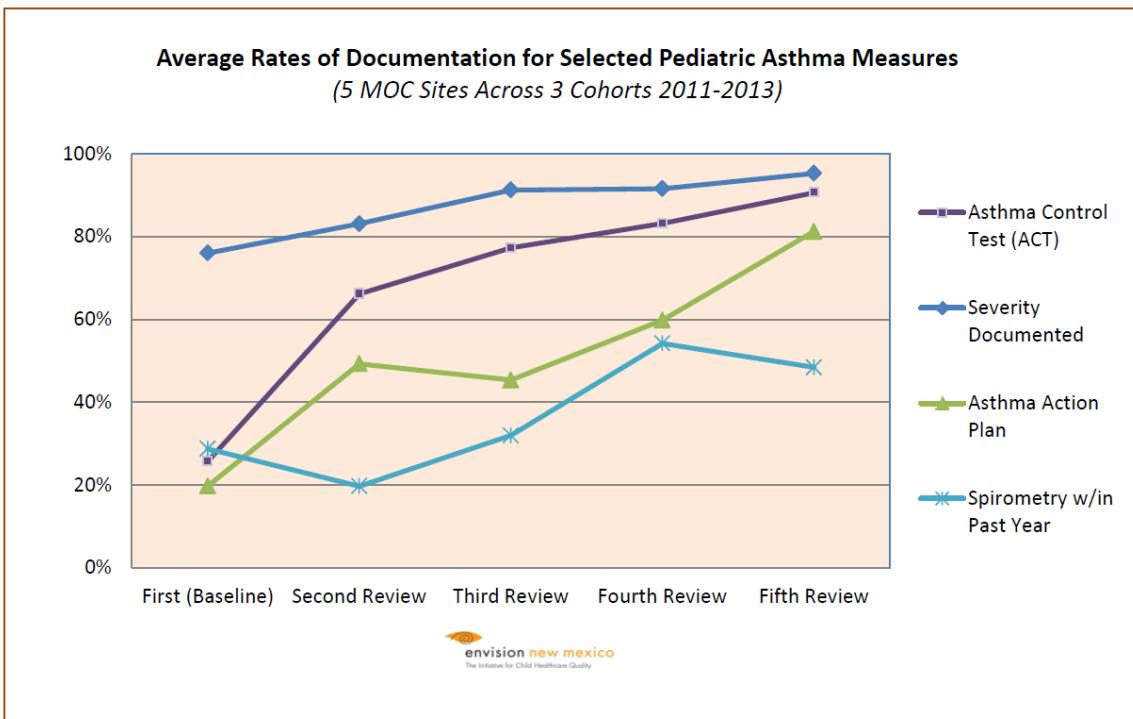
Appendix B. Outcome Measures

Envision New Mexico

Graph 1. Pediatric Overweight - Average Documentation Rates



Graph 2. Pediatric Asthma Measures – Average Documentation Rates

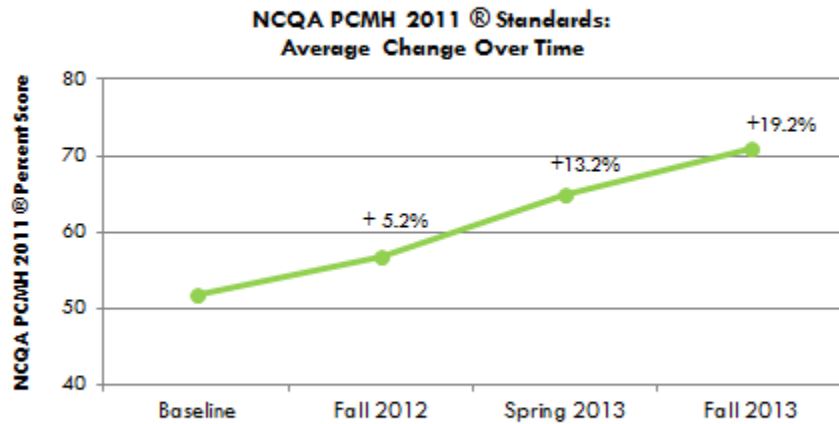


Appendix B. Outcome Measures (continued)

Oregon Pediatric Improvement Partnership

Chart 1

ECHO Practices Improvements on NCQA PCMH 2011®



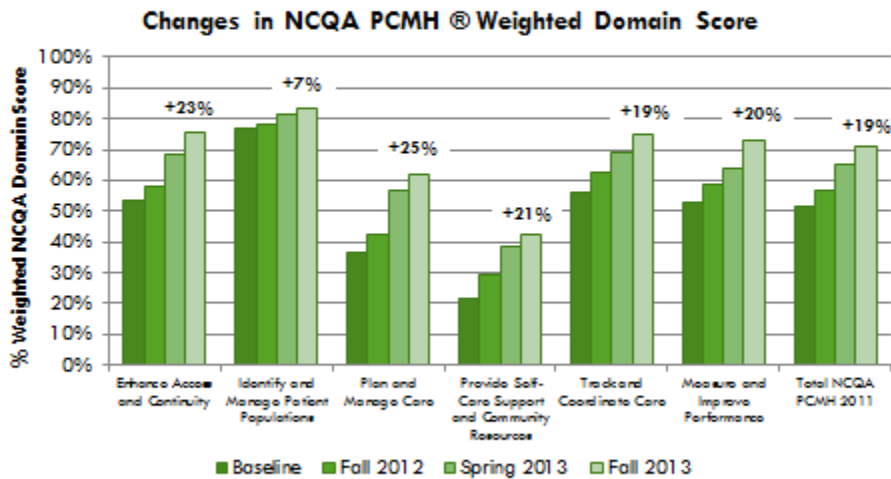
*Change indicated is change from baseline.

ECHO Learning Session #5

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Chart 2

Improvements in ECHO Practices: NCQA PCMH 2011®



ECHO Learning Session #5

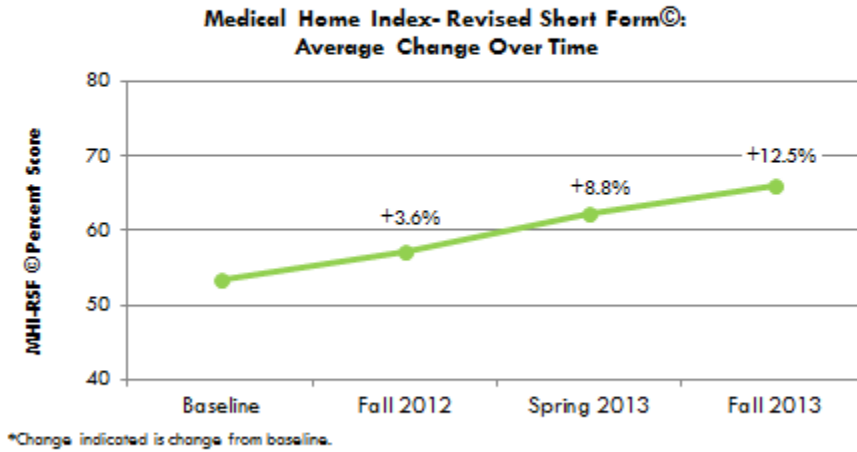
A project of the Tri-State Children's Health Improvement Consortium:
A CHIPRA Demonstration Grant Funded Project

Appendix B. Outcome Measures (continued)

Oregon Pediatric Improvement Partnership

Chart 3

ECHO Practices Improvements on MHI-RSF[®]

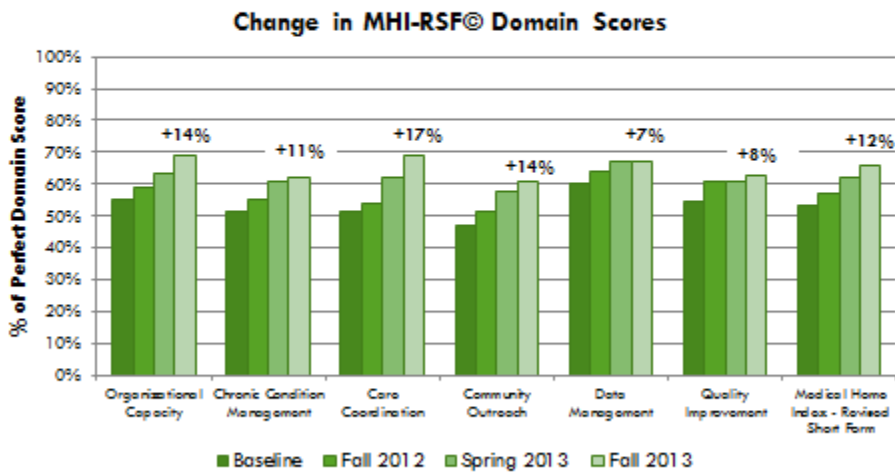


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Chart 4

ECHO Practices Improvements in the Medical Home Index – Revised Short Form[®]



ECHO Learning Session #5

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A CHIPRA Demonstration Grant Funded Project

Endnotes

- ⁱ Berwick, Donald. A primer on leading the improvement of systems. *BMJ* 1996; 312:619-622.
- ⁱⁱ Shaw J., Norlin C., Gillespie R.J., Weissman, M., McGrath J. The National Improvement Partnership Network: State-Based Partnerships that Improve Primary Care Quality. *Academic Pediatrics*. Nov-Dec 2013; 13 (6 Suppl):S84-94.
- ⁱⁱⁱ Data as of 2011 from Annie E. Casey Foundation Kids Count Data Center available at: <http://datacenter.kidscount.org/data/tables/3894-children-under-age-18-in-poverty?loc=33&loct=2#detailed/2/any/false/867.133.38.35.18/any/8250>; U.S. Census Bureau. State and County Quick Facts available at: <http://quickfacts.census.gov/qfd/states/35000.html>
- ^{iv} New Mexico Human Services Department. *Centennial Care: Ensuring care for New Mexicans for the next 100 years and beyond*. February 21, 2012.
- ^v *Ibid.* p. 24
- ^{vi} See <http://muafind.hrsa.gov/index.aspx>
- ^{vii} Nay, Barbara and Knivila, Kelly. “Oregon’s Coordinated Care Organizations—Health System Transformation or Managed Care Revisited?” *Insights* Winter 2013 available at www.williamette.com.
- ^{viii} *Ibid.*
- ^{ix} Oregon Health Authority. CCO Metrics Brief. February 2013. Accessed 5 February 2013 at <http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx>.
- ^x Berwick op.cit.