Maine Quality Counts
Better Health Care. Better Health.

FIRST STEPS

(Strengthening Together Early Preventive Services) Learning Initiative

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Partnering Organizations: Maine Quality Counts, MaineCare Services, Maine DHHS, MaineCare, Maine CDC, Maine Immunization Program, Maine Office of Information Technology, Muskie School of Public Service, USM, Vermont Child Health Improvement Program, Maine Chapter of the American Academy of Pediatrics, Maine Academy of Family Physicians, Maine Primary Care Association MaineHealth, Eastern Maine Health Systems, Central Maine Medical Group, MaineGeneral Health, Martin's Point Health Care, Maine Lead Program, Maine Developmental Disabilities Council

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES
Office of Information Technology
STATE OF MAINE

UNIVERSITY OF SOUTHERN MAINE
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First STEPS Learning Initiative
Practice Improvement Charter

Introduction: Consistent delivery of child health preventive services is an essential first step to building a healthy future for Maine. At the same time, there is strong evidence that there are barriers preventing children enrolled in Maine's Medicaid program (MaineCare) from receiving adequate levels of evidence-based preventive services.

The Problem: Medicaid provides a comprehensive and preventive child health benefit for children under the age of 21, known as the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit. Services provided under the EPSDT benefit are intended to screen, diagnose, and treat children eligible for EPSDT services at early, regular intervals to avoid or minimize childhood illness. EPSDT services cover medical, vision, hearing, and dental screenings. Complete medical screenings under the EPSDT benefit must include the following five components: a comprehensive health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations, appropriate laboratory tests, and health education.

Both nationally and in Maine, reports indicate that many children covered by Medicaid health insurance are not receiving required medical and other screenings and that those that do get screened are not receiving all components of the benefit. [1],[2] In Maine, based on claims data, only 40% of children enrolled in MaineCare received any EPSDT screening. The percentage of eligible children who received at least one screening service generally declines as children get older.[3]

Barriers: Improving EPSDT screening rates in practices in the past has been challenging as groups struggle to incorporate more screening forms, tests, and immunizations into already stressed office workflows. Busy practices face many challenges, such as identifying space and staffing to conduct additional tests and identifying appropriate methods of testing. In addition, providers may have concerns that doing more screening could expose additional challenges and issues, such as the need to offer appropriate and timely resources for families or referrals to specialists, which are not available in their geographic area. Other barriers include health information technology, such as the practice's ability and timeline to link with other systems, such as the state's ImmPact2 registry. Also, improvement of preventive care services is highly dependent on the ability of families to attend appointments. Practices will need help from multiple sources to engage and educate families and to improve access to care. In addition, with the emphasis on increasing preventive services, the risk of testing must be weighed against

[1] Office of the Inspector General, Most Medicaid Children in Nine States are not Receiving All Required Preventive Screening Services, May 2010.
[2] General Accounting Office. Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services. GAO-09-578. August 2009.
[3] Annual EPSDT Report (Form CMS-416) for FFY 2009. Available at: https://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp

potential benefit. For example, false positive test results can increase a family's stress and trigger additional expensive and invasive testing.

Many groups in Maine have worked hard to improve children's health, and these efforts have led Maine to be ranked 4th on the Commonwealth Fund Report for Child Health System Performance in 2010. However, rankings on specific measures reveal gaps in Maine's preventive care for children. Areas ripe for improvement include:

- 41st in immunization rates
- 14th for developmental screening (only 20% screened)
- 13th for preventive dental care
- 13th for healthy weight
- 11th for preventive medical care[4]

Proposal: To help address these significant gaps in care, Maine Quality Counts on behalf of the MaineCare program is introducing the "First STEPS (Strengthening Together Early Preventive Services) Learning Initiative," a comprehensive effort to provide outreach, education, and quality improvement support to primary care practices to improve rates of EPSDT services.

Mission: The mission of the First STEPS Learning Initiative is to improve preventive services for children with MaineCare.

Goals: As the first practice improvement effort of the Maine Improving Health Outcomes for Children (IHOC) Program[5], the First STEPS Learning Initiative aims to increase the rate of EPSDT (Early, Periodic, Screening, Diagnosis, and Treatment) services for children receiving MaineCare benefits. Maine Quality Counts will lead a learning initiative to support primary care practices in engaging in changes/interventions that will result in increased numbers of children with MaineCare receiving the required medical, vision, hearing, developmental, and dental screenings. It is expected that the positive impact of improved rates of preventive services, including reduced disease and earlier identification of special needs, will result in earlier access to needed medical and developmental services and ultimately improve health outcomes for children in the State of Maine. The learning initiative will also be building on the principles of the Patient Centered Medical Home (PCMH) pilot in the state. The American Academy Pediatrics states that, "a medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective." [6] Throughout the pilot, principles and best practices from the Patient Center Medical Home will be applied to the subject areas.

[4] Securing a Healthy Future: The Commonwealth Fund State Scorecard on Child Health System Performance, 2011

[5] In February 2010, Maine and Vermont were awarded a quality demonstration grant by CMS to Improve Health Outcomes for Children (IHOC) in both state through producing standard pediatric quality measures, improving information technology for sharing pediatric data, and supporting practice improvement efforts. The grant is funded through Section 401 (d) of the Child Health Insurance Program Reauthorization Act.

[6] Maine PCMH Pilot Practice "Core Expectations": 1. Demonstrated physician leadership, Team-based approach, Population risk-stratification and management, Practice-integrated care management, Same-day access, Behavioral-physical health integration, Inclusion of patients & families, Connection to community / local Healthy Maine Partners, Commitment to waste reduction, Patient-centered Health Information Technology, (Maine Maine Quality Counts, PCMH Pilot)

Target Audience: The focus of the First STEPS initiative will be to work with primary care practices that provide care to a high number of children covered by MaineCare. We will target the 20 practices that care for 1,000 or more children insured through MaineCare and the 4 Pediatric Patient Centered Medical Home pilot sites.

Methods: Maine Quality Counts staff will lead a two-year learning collaborative (Fall 2011-Fall 2013) based on the AAP Bright Futures Curriculum, working with 20 primary care practices to improve preventive care EPSDT rates including immunizations, well-child visits, developmental screening, and lead testing. We hope to partner with existing organizations in the state to also provide education around healthy weight and oral health.

The First STEPS Learning Initiative will be offered in three phases over the 2-year period, covering the following topics:

- Phase 1: Improve pediatric preventive services by implementing changes in the office system advocated by the AAP Bright Futures curriculum with a focus on improving immunization rates
- Phase 2: Improve developmental and autism screenings as well as lead and anemia screening
- Phase 3: Improve healthy habits including obesity screening and healthy weight promotion and improve oral health screening

Through all the phases, data will be collected on well visit rates and screening rates since routine physical examinations are the gateway to providing preventive services. Ideally, all practices interested in the initiative will participate in the first phase of the initiative. Since some of the primary care practices have participated in learning collaboratives in the past around certain topics and to accommodate varied levels of provider experience, the phases divide the topics in a way that provider groups can choose to participate in the areas that they feel they need the most assistance in phase 2 and 3.

In addition to being able to phase into the work based on topic areas, practices can participate in the improvement work on multiple levels. Faced by geographic challenges and competing priorities, providers and office staff will be able to select different levels of engagement including:

1. An IHI-style learning collaborative that runs 6-9 months with 2 learning sessions with between-session action periods supported by monthly coaching-webinars and monthly data collection around measures. The advantage of a collaborative is that we can apply to the American Board of Pediatrics and American Board of Family Practice for providers to receive Part 4 Board Certification MOC credit. Providers now need to obtain 40 points towards Board recertification by doing 2 MOC projects every 5 years either by participating in web-based programs or collaborative projects. In addition, many practices prefer the networking and support of other groups and consistent, timely coaching given around data to work towards achievable change. The downside for the

practices is that these can be time intensive and harder on groups that have to travel longer distances to attend.

2. A modified collaborative with one Learning Session followed by a provider self-enrolling in the AAP's EQIPP program that relates to the topic and completing a self-paced data entry process to get MOC credit. We are also looking at identifying other internet sites where providers can complete education online.
3. Self enrollment by providers in EQIPP and other online programs to work on a topic.
4. On-site improvement coaching where practice coaches, housed in existing health systems or PHOs, attend learning sessions and then return to the practice to work with providers one-on-one.
5. If providers do not need MOC, they can still participate and may benefit from the learning sessions for CME credit or find a site visit by subject matter experts to be valuable.

Evaluation: The IHOC grant supporting First STEPS requires participation in a national evaluation to assess how provider-based interventions, such as learning collaboratives and efforts to expand pediatric medical homes, impact care provided to children nationwide. The Muskie School of Public Service, USM, will be coordinating with the national evaluators to collect data locally on participating practices before and after participation to assess the impact on the number of screenings provided, the impact on medical home readiness, and the practices' perceived value and satisfaction with the trainings/collaboratives in improving care within their practices. This information will also help inform improvements in trainings and collaboratives for future phases of IHOC.

Expectations for practices participating in the Learning Collaborative for which providers will receive MOC credit: [7]

The Collaborative Faculty will:

- Provide evidence-based information on clinical and psychosocial subject matter, the application of that subject matter, and methods for process improvement. This will take place during and between Learning Sessions.
- Provide ongoing assessment of the extent to which the collaborative is meeting practices' needs through the collection and reporting of data on program implementation and outcomes.
- Offer coaching to practices.
- Provide communication methods to keep practices connected to the faculty and to colleagues during the Collaborative.
- Help assist practices identify barriers to providing care and work with health care systems and DHHS to reduce barriers
- Work with electronic systems, like the ImmPact2 immunization registry, to request changes to make it easier for practices do practice improvement by being able to run vaccination rate reports and recall/reminder letters for families
- The Collaborative will provide the opportunity for physicians to communicate amongst a community of peers who understand needs of practices and patients across the state

[7] Adapted from VCHIP Developmental Screening Charter

- The Collaborative will be able to give feedback back to the DHHS on best and promising practices and areas where policies may need to be changed to assist patients and practices.
- Practices will learn best practices around building a patient centered medical home and review QI methodology including the IHI Model for Improvement and Dartmouth Clinical Microsystems.

Participating practices who are working toward MOC credit are expected to:

- Perform pre-work to prepare for the Learning Sessions.
- Connect the goals of collaborative work to a strategic initiative in the practice.
- Send a multidisciplinary team to all Learning Sessions and participate in monthly phone calls.
- Provide resources to support their team including resources necessary for Learning Sessions, time to devote to testing and implementing changes in the practice.
- Perform tests of changes in the practice that lead to wide-spread improvements in the office practice.
- Perform tests of changes in the community that lead to improvements in the office practice.
- If working towards MOC credit, providers must submit monthly data related to well-defined measurements and participate in analysis of practice and state level results throughout the duration of the Learning Collaborative.
- Share information with the other participating organizations, including details of changes made and data to support these changes, both during and between Learning Sessions.
- Participate in data collection for the evaluation study of the collaborative

Participating Practices: We will recruit 20 practices to participate in each phase of this learning initiative. We will recruit 20 practice teams (including a physician, nurse, office manager) to participate in the first phase of MOC collaborative by the summer 2011. Our first focus will be on the 20 high volume MaineCare practices and the 4 pediatric practices in the Maine PCMH Pilot but initiative will be open to all interested groups.

Maine Quality Counts Staff / Project leaders: Amy Belisle, MD, and Sue Butts-Dion
Muskie School of Public Service, USM, Staff/Evaluation: Kim Fox, Erica Ziller, Sherrie Winton

Project Timeline: Fall 2011-Fall 2013

Setting the stage: There will be a site visit to several locations in Maine in May 2011 by Judy Shaw, EdD, MPH, RN, FAAP, Research Associate Professor of Pediatrics and Nursing, Executive Director, Vermont Child Health Improvement Program, University of Vermont-College of Medicine and Paula Duncan, MD, Youth Health Director, VCHIP, Clinical Professor of Adolescent Medicine, to lay the groundwork for Maine Child Health Improvement Partnership and highlight improvement areas in Bright Futures 0-5 years and Adolescent Health.[8]

[8] In order to build a sustainable model for improving health outcomes for children in Maine, there is a need to build a public-private child health improvement partnership.

<u>Phase One</u> (Fall 2011- April 2012): Implementing Bright Futures office systems approaches and Improving Immunization Rates

- **Phase One Learning Sessions:**

Learning Session 1 (Friday, September 23, 2011, 8-4 pm, Maple Hill Farm B&B Inn & Conference Center, Hallowell, ME)

- Learning Session with guest speaker, Judy Shaw, to provide training on Bright Futures implementation using office based systems. They will be building on the foundation of the patient medical home principles. They will teach office-based teams (provider, office manager, nurse) and practice coaches on quality improvement methods including:
  - Risk assessment and medical screening
  - Strength-based approaches
  - Development of recall and reminder system
  - Review the IHI Model of Improvement and Introduce concepts from Clinical Microsystems
  - Discuss Current Maine Immunization Rates, New Universal Coverage Law Going into Effect 2012, Working with Families around Vaccine Refusal, Improving immunizations rates with technical assistance from ImmPact2 experts
- **Learning Session 2** (Coordinate with PCMH conference on February 10, 2012 at the Augusta Civic Center, 8-4): The morning will focus on Pediatric PCMH and the afternoon will focus on Improving immunization rates and QI methodology.

- **Phase One Measures: Immunizations**
  - % of children who turn 2 yo of age who had 4 DTaP; 3 IPV, 1 MMR; 3 HiB; 3 Hep B; 1 VZV; 4 PCV; 2 Hep A; 2 or 3 RV; and 2 influenza vaccines by their 2nd birthday. *The measure calculates a combination rate and eleven separate vaccine rates.*
  - % of children who have received MMR, VZV, DTaP and IPV boosters by 6 yo
  - % of adolescents who have had meningococcal vaccine and Tdap or Td by 13 yo
  - % of adolescents who have completed the HPV series of 3 vaccines prior to their 13th birthday
- **Goal:** Improve the immunization rates based on population data by at least 4% within one year of project initiation in practices. Baseline rates are in parenthesis and are from the 2009 National Immunization Survey. The aim is to improve the immunizations rates by 4% for children under 2 for 4 DTaP (87%); 3 IPV (92%), 1 MMR (91%); 3 HiB (84%); 3 Hep B (90%); 1 VZV (90%); and 4 PCV (82%). We would aim to improve the rates of 2 Hep A (19%); 2 or 3 RV (28%); and 2 influenza vaccines (40%) by 10%. We

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Following successful examples such as the Vermont Child Health Improvement Program (VCHIP), Maine Quality Counts will work to bring together key stakeholders to identify strategic priorities for improving child health care, identify measurable goals for both inpatient and outpatient settings, and work with organizations to make change at both the practice and system level to improve health outcomes and access for children.

would aim to increase to 96% for 4-6 Year Boosters: for Polio (93%), DTP/DtaP/DT (94.5%), MMR (93.2%), and Varicella (90.5%). We would aim to increase Adolescent Boosters rates by 10% for: >= 1 Td or Tdap (76%), meningococcal (46%), and HPV (28%) based on 2009 rates.[9]

Phase Two (May 2012-Dec 2012): Improve developmental screening, and lead and anemia

- **Phase Two Learning Sessions:**
  - Learning Session 3 (May 11, 2012, 8-4 pm, Maple Hill Farm) – Improving developmental, autism, lead and anemia screening
  - Learning Session 4 (September 14, 2012, Freeport, Fall 2012) Follow-up on issues surrounding developmental, autism, lead, and anemia screening

- **Phase Two Measures: All Children**
  - % Documented use of a developmental screening tool by 12 mo (between 6-12mo) (PEDS or ASQ)
  - % Documented use of a developmental screening tool by 24 mo (between 12-23 mo) (PEDS or ASQ)
  - % Documented use of a developmental screening tool by 36 mo (between 24-35 mo) (PEDS or ASQ)
  - % Documentation of an autism-specific screening tool between 16-30 mo of age (MCHAT 1 or 2)
  - % children identified with a concern or developmental delay)(referred on PEDS/ASQ or MCHAT 2) have a documented follow-up plan (observation, recheck in office, or referral
  - Total number of referrals to CDS and Developmental Pediatricians each month under age 5
  - % of all children with whom a lead risk screening questionnaire was used to determine a child's level of risk at 12 mo (between 12-23 mo)
  - % of all children with whom a lead risk screening questionnaire was used to determine a child's level of risk at 24 mo (between 24-35 mo)

Optional Reporting for Practices:

- **Measures: MaineCare Only**
  - % children enrolled in MaineCare that had a venous or capillary blood sample tested for lead between 12 mo-23 mo and 24mo-35 mo
  - % of children enrolled in MaineCare who had a test for anemia between 12-23 mo and anemia between 24-35 mo

[9] US, National Immunization Survey, Q1/2009-Q4/2009†T, Estimated seasonal influenza vaccination coverage* among children and adults, by selected age and risk subgroups – United States†, Behavioral Risk Factor Surveillance System (BRFSS) and National 2009 H1N1 Flu Survey (NHFS), August 2009 through May 2010 for Children, 6 mos to 17 yrs 43% (not just children 6 mo-2yrs). Centers for Disease Control and Prevention, Vaccination coverage among children in Kindergarten—United States, 2006-2007 School Year. MMWR 2007. 56, 819-821. National Immunization Survey-Teen, United States, 2009.

<u>Phase Three</u> (Jan 2013-Sept 2013): Healthy Habits: Improving Healthy Habits: Healthy Weight and Oral Health Screening, Utilizing Community Resources

- **Phase 3 Learning Sessions:**
  - Learning Session 4 (Winter 2013): Healthy weight and oral health
  - Learning Session 5 (May 2013): Follow up on issues in learning collaborative on healthy weight and oral health

- **Phase 3 Measures:**
  - % yearly documentation at WCC of BMI % Report 3-11 yo, 12-<18 yo age groups and total. Report BMI stratification: underweight <5%; healthy weight: 5 to 84%;overweight: 85%-94%; obese 95%-98%, BMI>99%[10]
  - % 2–<18 yo who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
  - % of children with oral health risk assessment completed between ages 6 mo and 4 yo
  - % children with documentation of a dental home by 1 yo (yes/no) and then yearly until age 4
  - % of children with fluoride varnish applied who had a high/moderate oral health risk assessment

Measurement Issues:

- **Clinical data collection**: As the IHOC/CHIPRA project progresses over the next four years, it is envisioned that data collection for practice improvement projects will come from automated (electronic medical record/EMR) sources that do not require chart review. Also, the goal is to move from cohort data to population based data where available. Data for this project could potentially be collected and submitted from practice EMRs or registries (e.g. ImmPact 2, Clinical Improvement Registry (CIR), Meridios, or TEL) on a monthly basis. If automated data collection is not available and providers want to receive MOC credit, they would be required to conduct a chart review data on measures monthly.

- **Claims data collection:** Currently, the best estimates of EPSDT screening rates are obtained from claims data that are reported on the CMS 416 by the state to the federal government. At a practice level, rates for some of the measures are currently reported to the MaineCare PCCM practices biannually on the PCPIP/UR report. We plan to obtain baseline data for the targeted EPSDT screening rates using this claims data, and set goals for improvement prior to the beginning of each phase of the project.

Deliverables:

- Provide quality improvement training to practices to help improve immunization rates
- Provide training for practices to how to implement developmental and autism screening, improve interpretation of the screening tests, and work to improve follow-up rates.

[10] http://www.cdc.gov/nchs/nhanes.htm

- Provide training around guidelines and tools to improve lead, anemia, oral health, and healthy weight screening rates
- Help primary care practice improve care to be consistent with the PCMH/Bright Futures models
- Spread work of existing programs, such as *From The First Tooth Program* and the *Maine Kids Oral Health Partnership* so that 80% of high volume practices will obtain training around oral health risk assessments, fluoride varnish application, and dental home referral
- Spread availability of the AAP Bright Futures Toolkit to practices and provide training on tools including developmental delay, autism, and depression.
- Provide clinical expertise to MaineCare to update the Bright Futures well child encounter forms with information with the Bright Futures toolkit 3rd edition
- Address business model for practices- how quality improvement can increase WCC rates
- Identify barriers for MaineCare around practice improvement

Resources:
Sponsorship: MaineCare Services, DHHS, The grant is funded through Section 401 (d) of the Child Health Insurance Program Reauthorization Act.[11]

Partnering Organizations:
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