OPIP Annual Report (July 2011-July 2012*)

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* OPIP was formally established July 2010, with financial support from the Department of Pediatrics at OHSU and project-level contracts.
OPIP Vision & Mission

OPIP Vision:
To create a meaningful, long-term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

OPIP Mission:
The Oregon Pediatric Improvement Partnership is a public/private partnership dedicated to building health and improving outcomes for children and youth by:

- Collaborating in quality measurement and improvement activities across the state,
- Supporting evidence-guided quality activities in clinical practices,
- Incorporating the patient and family voice into quality efforts, and
- Informing policies that support optimal health and development for all children and youth.

Highlights of the Year

OPIP’s second year in operation was fast-paced with three active and extensive projects and a quickly changing health system. Health reform in Oregon is rapidly evolving with the implementation of the state’s Patient-Centered Primary Care Home Certification process, and the ongoing development of the Coordinated Care Organization structure. In addition to our project work, OPIP has remained nimble in keeping abreast of, informing, and responding to these reform changes.
Major Accomplishments

1. Project Work Supported Through Contracts with the Oregon Health Authority
   a. Assuring Better Child Health & Development-III (ABCD III)
      o Facilitation of a learning collaborative of eight Medicaid Managed Care Organizations focused on screening, referral and care coordination for children at risk for developmental, behavioral and social delays.
      o ABCD III team (including OPIP) received the DMAP Administrator’s Excellence Award (February, 2012).
   b. Tri-State Children’s Health Improvement Consortium (T-CHiC)
      o OPIP was part of the leadership team of this tri-state alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia with the shared goal of markedly improving children’s health care quality. OPIP supports overall efforts, consults on collection and use of the CHIPRA core measures, and is leading efforts around the collection, reporting and use of measures of medical home across 21 practices participating in medical home improvement efforts.
   c. Enhancing Child Health in Oregon (ECHO) - Medical Home Learning Collaborative
      o Advocated to Oregon Health Authority for a Learning Collaborative focused on practice-level medical home transformation for children and youth. Received funding, and in collaboration with the Oregon Rural Practice-Based Research Network, leading a learning collaborative with eight primary care practices around the state.

2. OPIP Organizational Development
   a. Hired three additional staff
   b. Launched the OPIP website (www.oregon-pip.org)
   c. Launched the OPIP QI Teamspace site (projects.oregon-pip.org)
   d. Developed a two-page overview about OPIP and related overview presentation

3. Informing Health Reform in Oregon
   a. Participation in Policy Workgroups/Advisory Committees:
      o Outcomes, Quality & Efficiency Metrics Workgroup (Governor-appointed)
      o Patient-Centered Primary Care Home (PCPCH) Implementation Taskforce
      o Tri-County Medicaid Collaborative (TCMC) Advisory Committee
   b. In Collaboration with partners, developed and disseminated five summary briefs to various entities within the Oregon Health Authority to inform health reform efforts
   c. Submitted four public comments to public requests for input on health reform efforts

4. OPIP Sponsored/Facilitated Broad Stakeholder Events:
   a. June 28, 2012 Grand Rounds at OHSU – Dr. Carl Cooley “Medical Transformation in Pediatric Primary Care”
   b. June 29, 2012 Meeting – Care Coordination for Children and Youth: Ensuring a family centered focus and synergy across care coordination efforts in Oregon

5. OPIP Executive Committee Engagement
   a. Monthly meetings facilitated and well-attended
   b. New member recruitment, member transition, and replacement
OPIP Organizational Development

OPIP currently has seven permanent staff. In addition, we hired a temporary consultant (Mimi Pham) to assist in the development of the OPIP website. The current organizational chart can be found below:

Figure 1: OPIP Organization Chart (July, 2012)

New Staff

This year we have had some staff turnover, but have also been fortunate to have hired new positions. Dr. O’Haire (formerly in the Senior Research Associate position) transitioned in June to pursue a career in nurse midwifery. Our previous Research Assistant, Brian Ambuel, also transitioned out of OPIP at the end of June in order to pursue graduate school.

We have hired three new staff and are excited about what they each bring to the team:
Katie Conner, MPH, Practice Facilitator

Ms. Conner is the lead OPIP Practice Facilitator who provides the "at-the-elbow' support to practices on practice transformation and systems level improvement. Ms. Conner is currently working with five sites on medical home quality improvement and helping the monthly Learning Collaborative calls. Katie is also involved with the medical home evaluation data collection and reporting. Katie received her Bachelor’s of Science in Public Health: Health Promotion Health Behavior from Oregon State University and her Master’s in Public Health: Health Management and Policy from Portland State University in 2011. She completed an internship with OHSU in Family Medicine and Internal Medicine working on the implementation and evaluation of a medical home model. After completing her internship, Katie was hired in Family Medicine to manage a quality improvement grant that focused on the care of patients with mood disorders.

Amber Laurie, Sr. Research Assistant

Ms. Laurie joined OPIP in March of 2012 as a Senior Research Assistant. Ms. Laurie received her Bachelor of Arts in Psychology from Macalester College in 2007, and she is currently pursuing Master’s in Biostatistics at Oregon Health & Science University. Prior to working at OPIP, Amber was a Senior Research Assistant and Lab Manager at the Sleep and Mood Disorders Laboratory at Oregon Health & Science University where she was project manager of two NIH-sponsored grants. Ms. Laurie’s primary work at OPIP includes quality measurement and evaluation of improvement projects focused on medical home and care coordination for children at risk of developmental, behavioral and social delays. Ms. Laurie has a passion for early childhood health and education, and she has taught in Head Start and other Pre-Kindergarten programs.

Kiara Siex, MPH, Research Assistant II

Ms. Siex joined OPIP in June of 2012. She has a Bachelor of Arts in Political Science from Western Oregon University, and a Master of Public Health in Health Management & Policy from Oregon State University. While earning her MPH, Ms. Siex interned for the Oregon Department of Human Services where she worked at the Governor’s Advocacy Office on quality improvement strategies for delivery and outcome of public service programs across the state, and was involved with the DHS/OHA transformation initiative where she trained in LEAN QI strategies. Prior to joining OPIP, Ms. Siex also spent time with Salem Hospital’s Health Information Management Department where she was involved in a QI project on ICD-10 coding initiatives and the organizational impact of HIM technology transitions. Ms. Siex’s interests are with health policy, health promotion, and quality improvement mechanisms.
Annual Evaluation of OPIP Leadership Team

OPIP leadership is committed to gaining input and guidance from the OPIP Executive Committee in order to ensure that key goals and objectives are met. As part of this commitment, Ann Skoog (OPIP Program Administrator) developed an evaluation survey of the OPIP leadership team that was distributed to the OPIP EC members, and the findings are being used to identify areas for improvement and methods to better engage and partner with the OPIP EC.

Centralized Space for OPIP

Thanks to the partnership of the Department of Pediatrics and the Child Development and Rehabilitation Center (CDRC), we were able to secure space within the CDRC (707 SW Gaines Street) where all our staff members are housed in close proximity to each other. This allows for improved efficiency, better staff communication, and team development. We are located on the 2nd floor of the CDRC in the office spaces accessed through Room 2214.

OPIP Communication Materials

OPIP Executive Leadership developed a brief, two-page summary of OPIP’s formation and activities to use as promotional material. This brief is available on the website, and has been distributed at the OPIP-sponsored Grand Rounds at OHSU in June, as well as the Grand Rounds presentation given in July.

Launch of the OPIP Website (www.oregon-pip.org)

We are pleased to announce that our website, www.oregon-pip.org, went live to the public on June 27, 2012. While some parts are still in development, we are excited to have a website that provides background information about OPIP. We are committed to maintaining the website and to ensure relevant tools and resources are provided. Genesis Duncan (web design contractor) and Mimi Pham (Portland State graphic design intern) were key partners in the development of the website.

Launch of the OPIP QI Teamspace (projects.oregon-pip.org)

June 2012 also marked the launch of our online community for quality improvement, QI Teamspace. This site allows us the ability to create work and share spaces online for the various projects that we facilitate. Features include resource/document sharing, calendaring, blogs and message boards, data collection and display, and overall communication and collaboration. Users are given a unique log in, and are assigned specific privileges for each project to which they are attributed. This level of security allows for the collection and dissemination of secure information. We are currently using the site for our ECHO and TCHIC projects, and will use it as a valuable collaborative tool for future projects.
Highlight of Key Activities Relative to the OPIP Mission

On the following pages is a high-level summary of the key activities, by project (where possible), that have been conducted relative to the four primary strategies of the OPIP mission. Project-specific summaries are also available on the OPIP website.

#1: Collaborating in Quality Measurement and Improvement Activities

All three of the current OPIP projects involve specific activities focused on collaborative efforts with key partners on quality measurement and improvement. This is the primary focus for OPIP, and staffing has been intentionally recruited for those with related skills and experience. For each of the projects, a Learning Collaborative model adapted from the Institute for Healthcare Improvement is being utilized. A learning curriculum ensures that key goals and objectives are addressed, and collaborative calls/meetings promote shared learnings across participants in the improvement efforts. Figure 2 below provides a high-level summary of the key partners OPIP has the honor of collaborating with, and a high-level overview of the measurement and improvement activity focus areas.

**Figure 2. Overview of OPIP Measurement and Improvement Projects: Collaborators, Measures, and QI Focus (July, 2012)**

<table>
<thead>
<tr>
<th>Collaborative Partners:</th>
<th>Measures – Data Source:</th>
<th>Quality Improvement Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCD III (Subcontract from DMAP)</td>
<td>-- CHIPRA Core Measures &gt; Claims/Enrollment Data &gt; Medical Chart Reviews &gt; Other data sources</td>
<td>-- Learning collaborative of 8 MCOs -- QI goals specific to children at risk for or with social, emotional or developmental delays -- Collaborative has four goals specific to screening/surveillance, referral, tracking of referrals and ensuring children get to services, and care coordination</td>
</tr>
<tr>
<td>Collaborative Partners:</td>
<td>Measures – Data Source:</td>
<td>Quality Improvement Focus:</td>
</tr>
<tr>
<td>TCHIC (Subcontract from OHPR)</td>
<td>-- TCHIC Medical Home Office Report Tool (MHORT) -- Surveys -- Medicaid staff, providers</td>
<td>-- Focus on medical home transformation across all three states -- Learning curriculum also focused on meaningful, useful quality measurement and how it can be improved and used to guide/track improvement efforts -- OPIP assisting on the across TCHIC Learning Curriculum</td>
</tr>
<tr>
<td>Collaborative Partners:</td>
<td>Measures – Data Source:</td>
<td>Quality Improvement Focus:</td>
</tr>
<tr>
<td>ECHO (Contract from OHPR)</td>
<td>-- TCHIC Medical Home Office Report Tool (MHORT) -- Surveys -- Providers and office staff</td>
<td>-- Focus on medical home transformation -- OPIP leading the development of the Learning Curriculum and Learning Collaborative (with collaboration from ORPRN)</td>
</tr>
</tbody>
</table>

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**ABCD III (Subcontract from DMAP)**

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**TCHIC (Subcontract from OHPR)**

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**ECHO (Contract from OHPR)**

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Assuring Better Child Health and Development (ABCD) III in Oregon

The ABCD III project seeks to make improvements in policies and systems in order to better identify, refer, and coordinate care for children at-risk for developmental, social and behavioral delays. In Oregon, the Division of Medical Assistance Programs (DMAP) is leveraging the Performance Improvement Project (PIP) structure required as part of the Medicaid Managed Care Organization (MCO) contracts. OPIC was hired to serve as the External Quality Review Organization-like (EQRO) for ABCD III. As part of this role, we have developed the ABCD III PIP, informed by community engagement with parents and providers, and are facilitating a Learning Collaborative of eight managed care organizations. OPIC facilitates this collaborative process through monthly meetings with all the plans, periodic one-to-one check-ins, and monthly summary reports on each plan’s progress. A component of the PIP was a medical chart review conducted by the eight managed care plans to assess screening and surveillance, referral tracking and care coordination patterns documented in the chart. OPIC developed the medical chart specifications that were used by the MCOs. Additionally, OPIC is supporting efforts focused on engagement and shared learning between community-level partnerships needed for the ABCD III effort to be successful with Early Intervention, CaCoon, and other community based providers. OPIC is responsible for engaging with these key partners and the ABCD III advisory group to ensure that key findings are shared and opportunities and leverage arms within respective organizations are identified. Lastly, OPIC is providing consultation to DMAP on the evaluation measurement of the ABCD III efforts and implications for the state-level, CCO-level, provider-level and community based measures.

Highlights of Key ABCD Activities and Learnings Related to Measurement and Improvement:

- The eight managed care organizations are designing and implementing improvement interventions to improve these systems at the practice level, and as experienced by families (Table 1).

<table>
<thead>
<tr>
<th>Provide ASQ -3 to Practices</th>
<th>Kaiser</th>
<th>MCO1</th>
<th>MCO2</th>
<th>MCO3</th>
<th>MCO4</th>
<th>MCO5</th>
<th>MCO6</th>
<th>MCO7</th>
<th>MCO8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASQ Reminders to Parents</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Telephone Interviews with Parents</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Schedule START Trainings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Referral Follow-up</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>Clarify/Detail Policies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Provider Website</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Member Website</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>8</td>
</tr>
<tr>
<td>Member Mailings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Referral Form Detailing With Providers</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td></td>
<td>5</td>
</tr>
<tr>
<td>Referral Form- HER</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Peds Care Manager Functions</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>EI/Practice Coordination</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Coordination w/CaCoon</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
Through the OPIP-led learning collaborative, presentations were provided about the Oregon Pediatric Society’s Screening Tools and Referral Training (START) program, Title V’s Care Coordination Program (CaCoon), State-Level Early Intervention (EI), and the county-level local contractors. All of the plans engaged with at least one of these collaborative partners, and spotlighted in this collaborative effort as part of their PIP implementation process.

- It has become increasingly apparent that engaging providers and clinic personnel is not something that a majority of the plans have either invested in, and/or are skilled at doing. As such, some of the proposed practice-level improvements have been slow, hard to come by, or abandoned completely. There are, however, a few plans that have successfully facilitated improvements at the practice level. An example of this is Oregon Dental Services (ODS) which has brokered relationships and agreements between practices in Malheur County and the local EI contractor. As a result of these partnerships, adjustments to referral tracking, follow-up, and coordination practices have been made, leading to improvements in the system.

- An additional barrier for MCOs is that they are being asked to devote resources to ABCD III while significant health reform is being implemented statewide. All of the plans participating in ABCD III are participating in the transition to Coordinated Care Organizations (CCOs), and this effort has overshadowed smaller projects like ABCD III. We are currently in the process of wrapping up implementation work, and are beginning to discuss spread and sustainability planning.

A key component of the ABCD III is the collaboration across sectors (DMAP, Public Health, and Early Intervention) at the state level in order to utilize learnings to inform state-level policies and systems, and guide improvements in the care provided.

- A key example includes updates to ecWeb, the data system utilized by the regional Early Intervention (EI) contractors across the state. Utilizing information and learnings from ABCD III, the state-level EI community adopted improvements to their data system to better document information about the child’s primary care provider, as well as when and what follow-up information and feedback from EI evaluation was sent back to the primary care provider. In addition, ecWeb was updated to include a standardized evaluation documentation form. This form allows for a standard evaluation summary to be created automatically, which can then be sent to the primary care provider. The content and structure of this summary report is based in part on learnings from the ABCD III project, and was supported by the state-level EI partners on the ABCD III team.

- Another example is the successful leverage of the data integration that exists between EI and Medicaid data to guide care coordination efforts. Through the ABCD III efforts, the eight MCOs received data files of children enrolled to their plans for which Medicaid had been billed by Early Intervention services. Previous to this project, none of the eight MCOs had known these children were in EI services. A key component of their ABCD III efforts has been identifying methods for how they can better manage and coordinate care for these children.
• Measures of developmental screening are a part of the national CHIPRA measurement set, and are included in the current frameworks for the Coordinated Care Organizations (CCO) and the Patient-Centered Primary Care Homes (PCPCH) efforts.
  o A number of relevant learnings from the ABCD III project and the data that has been collected through this effort are being used inform the improvement, refinement, and use of the developmental screening measures in this health reform effort.
  o Ms. Reuland helped to develop the current CHIPRA core measure on developmental screening while at the CAHMI. Currently, she continues to serve as a co-measure steward for the measure and is highlighting, at a national level, the learnings that have been gathered about the reliability and validity of claims data and medical chart data on screening, referral and care coordination, and opportunities for improvements to the measures and related policy-level improvements identified.

**Tri-State Children’s Health Improvement Consortium (T-CHIC)**

OPIP has the privilege of being a partner on the Tri-State Children's Health Improvement Consortium (T-CHIC). The Tri-state Children's Health Improvement Consortium is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia, formed with the goal of markedly improving children's health care quality. In February 2010, the Oregon-led consortium was awarded nearly $11.3 million over a five-year period by the Centers for Medicare & Medicaid Services (CMS) via CHIPRA Quality Demonstration Grants. Ms. Reuland, from OPIP, was part of the original team that wrote the grant that was awarded.

OPIP is currently in the third year of this five-year contract with T-CHIC, and OPIP is a partner with the Child and Adolescent Health Measurement Initiative (CAHMI) on this work. OPIP’s role across T-CHIC efforts is in the following four areas:

1. **T-CHIC Leadership:** Ms. Reuland serves on the T-CHIC leadership team and provides assistance, facilitation, and consulting across T-CHIC activities and project management.

2. **T-CHIC Learning Curriculum and Collaborative Across T-CHIC:** An integral component of the T-CHIC effort is to facilitate a Learning Collaborative and Learning Curriculum to support across state learnings and provide comparative state data about to motivate and inform improvement learnings, and generate across T-CHIC innovation. OPIP assists in the development and implementation of the Learning Curriculum.

3. **Consultation on Data Collection and Reporting of the CHIPRA Core Measures:** Ms. Reuland provides consultation to T-CHIC on implementing the core measures. This includes assistance in interpreting and adjusting the specifications to meet the state program structure, participating practices' capacity or needs, and other factors. A related component of this work is technical assistance and consultation about how the core measures can be reported at the practice-level using state data.

4. **Medical Home Quality Improvement, Measurement and Evaluation:** OPIP is responsible for designing the Medical Home Office Report Tool (MHORT), the implementation
processes, and for analyzing and reporting the MHORT data across the 21 primary care practices participating in the TCHIC improvement efforts. A key part of this work is using the MHORT findings to guide and refine the practice-level improvement efforts and to inform the policy-level efforts needed to support medical homes.

**Highlights of Key TCHIC Activities and Learnings Related to Measurement and Improvement:**

- **OPIP helped to develop a T-CHIC learning curriculum and related calls that began in November 2011. In collaboration with the T-CHIC partners and based on priorities identified at the June T-CHIC meeting, OPIP also created the Learning Curriculum that will be used to facilitate the T-CHIC Learning Collaborative through June 2013.**
- **T-CHIC held a successful two-day meeting of the project partners in June 2012. OPIP played a key role in the design of the meeting and facilitated a number of sessions meant to leverage and use the medical home data collected to inform the improvement efforts at the state and practice-levels.**
- **OPIP led the development of the T-CHIC MHORT that was collected at baseline across all 21 practices participating in the medical home improvement efforts, and will be periodically collected every six months. Included in this tool are required elements that must be reported to the National Evaluator for the CHIPRA demonstration project. OPIP worked collaboratively with the Oregon Rural Practice-Based Research Network (ORPRN) to build the MHORT into REDCap. Building the tool in RedCap allows it to possibly be used by other non-TCHIC partners in a standardized way, which can allow for comparison data to be collected and shared with future partners focused on medical home transformation.**
- **Thanks to collaboration with the T-CHIC partners, the baseline data was collected and entered for all 21 practices. OPIP cleaned and analyzed the data, and has created over 35 reports based on the data findings. The required data file was disseminated to the National Evaluator, and strategic reports were provided to the T-CHIC project team and to each of the 21 participating practices, and the findings were used to inform and guide modifications to the Learning Curriculum.**
- **Identification of children and youth with special health care needs (CYSHCN) has been identified as a shared priority for T-CHIC. A key learning from Oregon in this effort has been that targeted and significant technical assistance is needed to support practices in developing standardized systems to identify children and youth with special health care needs. OPIP will be documenting the key learnings from these efforts in an Issue Brief this Fall. Preliminarily learnings spotlight the limitations of current EMRs in identifying a non-condition specific group of CYSHCN, which is essential, given the CHIPRA legislation expectation that measures be stratified by this sub-population. In Oregon, this process is ongoing. Current payment and office systems that incentivize condition (and thus billing code) specific methods necessitate an enormous amount of technical support to identify and implement sufficient “workarounds” to accomplish a more general approach.**
• As part of the development work for the T-CHIC MHORT, OPIP has enhanced and maintained a database of measures of medical home based on various data sources (claims data, medical chart review, provider report, provider survey, parent survey).
• Ms. Reuland was able to work with the Institute for Healthcare Improvement (IHI) to receive a discount for the T-CHIC community to the IHI Primary Care Coaching Program. OPIP’s Katie Conner is enrolled in this program and is receiving intensive coaching that will benefit current and future OPIP projects focused on engaging primary care practices.

Enhancing Child Health in Oregon (ECHO) Medical Home Learning Collaborative

The original CHIPRA grant to the Tri-state Children’s Health Improvement Consortium (T-CHIC) did not include a specific learning collaborative within the state of Oregon. Through work with the Oregon Office for Health Policy and Research (OHPR) and Division of Medical Assistance Programs (DMAP), and based on a summary brief developed by the OPIP EC partners, OPIP was able to negotiate the creation of such a Learning Collaborative. Along with the Oregon Rural Practice-Based Research Network (ORPRN), a proposal was created and subsequently approved by OHPR and DMAP. This proposal was created with significant targeted feedback by our Executive Committee to ensure that the work of the Learning Collaborative would be meaningful to primary care practices, and feasible for OPIP to manage. The contract officially began in July 2011.

In the following month, OPIP recruited five practices and ORPRN recruited three practices. The recruitment process included intentional inclusion of a variety of practice characteristics including size, urban versus rural locations, and Pediatric and Family Medicine practices. Our initial intent was to find a mix of practices using Electronic Health Records versus paper charting, but with Meaningful Use incentives to implement EHR systems, both OPIP and ORPRN had some difficulty finding practices that were using paper charting and intended to stay that way.

OPIP also established a partnership with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) on the ECHO project to provide guidance and technical assistance on the curriculum and practice-level technical assistance specific to special health care needs, but also to ensure a family/patient-centered focus.

The pre-work for the ECHO Learning Collaborative included extensive work in curriculum development, as well as comprehensive baseline assessment of the eight practices recruited to participate in the collaborative. The Learning Collaborative is based on a modified Breakthrough Series Collaborative model, with five learning sessions planned. Between learning sessions, practices engage in quality improvement activities anchored to the goals of the project, with monthly “at-the-elbow” assistance from Performance Improvement Specialists and senior staff. Additionally, monthly conference calls have been conducted that support the activities of the practices, as well as addressing the practices’ identified needs. The curriculum
includes goals and objectives for (a) the overall Learning Collaborative, (b) the Learning
Sessions, (c) the action periods/ practice facilitation, and (d) the monthly conference call
proposed subjects. As the curriculum is designed to be responsive to practice needs, it is
flexible and undergoes changes when appropriate.

The overall goals of the Learning Collaborative are to:

1. Assist practices in implementing components of a medical home for children and youth,
as articulated in the standards of the Oregon Patient-Centered Primary Care Home
(PCPCH).
2. Identify and support meaningful systems and change processes that primary care homes
can implement to achieve the standards in the PCPCH for children and youth.
3. Identify and categorize the challenges and barriers at the practice level in achieving the
goals of the PCPCH Standards, and evaluate the practice’s experience of care and of
implementation of the PCPCH Standards.
4. Identify specific PCPCH measures (either existing or newly developed concepts
implemented in the Learning Collaborative) that achieve the goals articulated in the
PCPCH standards.
5. Develop a community and targeted process by which primary care homes can learn
from each other about innovative care systems.
6. Create a manual of implementation guidelines and recommendations for Pediatric and
Family Medicine practices, across a diverse range of clinic settings, who are interested in
achieving the PCPCH standards.
7. Assess the impacts of Medical Home / PCPCH designation on patient outcomes,
including patient experience of care.

The five learning sessions are currently planned to cover core practice transformation elements
identified through a literature review and through the baseline assessments of practices. The
subjects of the five learning sessions are:

- Identification of Children and Youth with Special Health Care Needs (CYSHCN)
- Care Coordination
- Behavioral Health Integration
- Patient Engagement
- Sustaining Change

Each learning session is designed to allow practices to share project gains, followed by a
keynote address, and concluding with time for practices to plan out their activities for the next
action period.
Highlights of Key ECHO Activities and Learnings Related to Measurement and Improvement:

- The first ECHO learning session was held in November of 2011, and covered Identification of CYSHCN. David Bergman, MD from Stanford University gave the keynote address. This was chosen as our first subject as it became evident that care coordination activities (one of the key elements in Medical Home practice transformation) cannot happen unless providers are able to accurately identify and track the population in need of care coordination services.
  - Each of the eight practices then focused on quality improvement processes during the next six-month “action period” focused on implementing systems to identify CYSHCN.
  - All eight practices have sustained at least some degree of implementation of the CAHMI screener to identify CYSHCN using a consequences-based, non condition-specific approach.
  - Hillsboro Pediatrics implemented the CAHMI screener across all providers and is manually tracking the population, and Providers are using the screener results to facilitate conversations with families.
  - Childhood Health Associates of Salem devised a novel tracking system for CYSHCN, identified using the CAHMI screener by utilizing a specific V-Code; this allows them to query the electronic medical record in order to track this population.

- The second learning session was held in May 2012, and covered care coordination within primary care. Bob Nickel, MD, a developmental pediatrician with the Child Development and Rehabilitation Center at OHSU, and a consultant to the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), gave the keynote address. Three parents of CYSHCN participated in the keynote by interspersing their experiences with health care between Dr. Nickel’s comments.
  - Each of the eight practices have focused on quality improvement processes during the current “action period”, focused on implementing and improving care coordination systems in their practice.
  - Seven of eight practices have a defined care coordinator role within the practice, and the one remaining practice is in the developmental stages of adding that role.
  - Woodburn Pediatrics added a care coordinator, and has developed a shared care plan template that they are currently piloting and refining.
- Childhood Health Associates of Salem has implemented a shared care plan template into their EMR, that allows providers, care coordinators, and others on the care team a central place to document and access shared information for coordination.

- Hillsboro Pediatrics has added care coordination functions to existing nursing positions. These coordinators are currently working with families of identified CYSHCN to develop shared care plans.

- The Children’s Clinic (TCC) has devised and piloted an EMR workaround to facilitate referral tracking that involves a “dummy desktop” which leaves referrals to outside providers open until feedback is received. At that point, TCC staff close the referral, and complete the communication loop between the medical home and the outside entity.
#2: Supporting Evidence-Guided Quality Activities in Clinical Practices

One of the fundamental components of our mission statement is the implementation of evidence-guided improvements in clinical practices. Each of the three current projects within OPIP is focused on the implementation of evidence-based guidelines, related developmental screening, and medical home. Furthermore, the projects are also addressing components of the guidelines for which further evidence is needed, and on-the-ground implementation and the related learnings to inform the evidence-based guidelines are being gathered.

**Assuring Better Child Health and Development (ABCD) III**

OPIP developed the ABCD III PIP infrastructure and expectations and ensured that the four goals of the PIP were aligned with the evidence-base around screening, referral, and care coordination.

Over the course of the last year, OPIP has presented and regularly reinforced elements of the Bright Futures recommendations, including the evidence-based clinical guidelines around standardized developmental screening with a validated tool at recommended periodicities. As a result, many of the MCOs have spent time clarifying internal processes and policies around these recommendations, and also communicating with contracted providers about both the expectations and reimbursement procedures for carrying them out. Additionally, a few plans have worked with practices around improving processes for referring to and coordinating with EI.

ABCD III is also helping to inform and articulate innovative ways in which health systems (DMAP, MCOs) can help to support recommended care coordination. These new innovative approaches, when summarized in the final report, will provide important contributions to the field in methods for operationalizing care coordination.

Additionally, through the medical chart reviews designed by OPIP, data has been gathered and is being analyzed by DMAP and the MCOs to assess the degree to which the Bright Futures recommended care is being provided, as documented in the medical chart. The findings from this chart review will inform future efforts focused on ensuring evidence-based care is provided, and the related policy- and practice-level improvement efforts that are needed.

**Tri-State Children’s Health Improvement Consortium (T-CHIC)**

As was described earlier, the T-CHIC efforts are focused on supporting evidence-guided quality activities in clinical practices via two main methods:

1. Practice-based improvement efforts focused on medical home transformation.
2. Collection and more importantly use of, the CHIPRA core quality measures to understand the quality of care provided and to use the information collected, when relevant and applicable, to improve care.

**ECHO Medical Home Learning Collaborative**

In this project, OPIP is working directly with practices to implement principles of medical home. The practices involved in the ECHO Learning Collaborative started their work toward becoming high functioning medical homes by implementing processes by which they can identify Children and Youth with Special Health Care Needs (CYSHCN) in a non condition-specific way. Unlike the adult population, identifying special needs populations in pediatric practices is complex for a variety of reasons:

1. The prevalence of any given chronic condition among children is relatively low.
2. There are a large number of applicable diagnoses, many of which are very rare.
3. Identification strategies that rely on diagnoses have been known to miss children who should qualify as having chronic conditions (due to coding errors, misdiagnoses, or the global or developmental nature of some childhood problems).
4. Multiple definitions of children with chronic conditions results in a different set of conditions and/or codes to operationalize the definition (from CAHPS Health Plan Survey and Reporting Kit 2008).

Enhanced care coordination functions are considered foundational for medical homes; however, processes for the identification and tracking of CYSHCN must be completed before care coordination programs can be implemented. For this reason, our first learning session focused on practice-based identification of CYSHCN. David Bergman, MD gave the keynote address for this learning session in November 2011.

Following the learning session, all practices have implemented the CAHMI screener for identification of CYSHCN. This screener is a consequences-based tool that is based on the Maternal Child Health Bureau definition of CYSHCN. This implementation was supported by conference calls addressing further issues around using the CAHMI screener, community based resources (specifically CaCoon) and care coordinator job descriptions.

The next learning session took place in May 2012, and focused specifically on Care Coordination, and featured a keynote address by Bob Nickel, MD who reviewed the contents of OCCYSHN’s toolkit for care coordination. One of the key practice changes currently being implemented is the use of shared care plans, including patient goal-setting.
#3: Incorporating the Patient and Family Voice into Quality Efforts

**Assuring Better Child Health and Development (ABCD) III**

One of the key OPIP activities over the last year of the ABCD III PIP was an extensive community engagement process to inform the work of the MCOs. OPIP developed a model for community engagement that built off the Community Café model for parent and family participation, but also involved the entirety of stakeholders, and anchored to the principles of quality improvement. This included a staggered, systematic approach that built off data collected and assessed, and actions developed. Our intent was to create a process by which stakeholders were individually engaged, their perspectives collected and analyzed, and their interests identified before a group-level meeting was held involving the various stakeholders from different perspectives.

The third and final stage of the engagement process (group-level engagement) took place in August 2011. Here, MCOs attended a meeting with a diverse group of stakeholders, including a strong parent presence, where ideas and viewpoints were shared with regard to the shared system in question. OPIP has spent a significant amount of time as part of the ABCD III work over the last year keeping the results of the engagement process in the forefront of the MCO’s consciousness, emphasizing the importance of the patient and family voice in systems improvements. This has been a particularly important aspect of our work, as this type of engagement and the use of the information it provides are not things that plans use to facilitate. While this has been challenging, and much has been learned about community engagement to inform the PIP process, the value of this activity is increasingly apparent.

**Tri-State Children’s Health Improvement Consortium (T-CHIC)**

The T-CHIC partners have agreed to collectively support the collection of the CAHPS-Clinician and Group(CG) – Patient Centered Medical Home (PCMH) across the practices participating in the medical home improvement efforts. This is an exciting pilot of how Medicaid can partner with practices to collect practice-level, patient/family reported information to guide and track improvement efforts. OPIP has been supporting the T-CHIC team leading this effort, and a majority of the ECHO practices are participating in this important patient-centered effort. OPIP also partnered with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) to have three parents of children and youth with special health care needs present...
at the T-CHIC meeting focused on care coordination. These parents served as the keynote and provided invaluable perspective and insight about family/patient centered care coordination.

**ECHO Medical Home Learning Collaborative**

Through the baseline assessment of practices, project staff learned that many of the weaknesses reported by practices related to patient engagement, utilization of patient self-management strategies (including shared care plans, transition plans, and patient self-education), and implementation of parent advisors in QI projects and practice advisory committees. Due to these shortfalls, Patient Engagement is one of the planned learning sessions for the ECHO Learning Collaborative. Project staff have also incorporated shared care plans and transition plans into the evolving learning curriculum, which is a technique for engaging the patient in the management of their chronic illnesses.

Furthermore, staff learned that while practices had incorporated some condition-specific identification of Children and Youth with Special Health Care Needs into their workflows, none of the practices continue the process of Identification of CYSHCN with a complexity assessment to address the specific patient and family strengths and needs. Furthermore, condition-specific approaches to identifying CYSHCN fails to assess whether having a medical condition results in increased care coordination needs for the families. A consequences-based, non condition-specific approach is therefore preferred and has been taught to the practices, using the CAHMI Screener for CYSHCN. All practices have adopted this screener and continue its use. Complexity scales have also been addressed during the ECHO Learning Sessions, and practices have been taught that care coordination needs of families depend on the family strengths, structure and resources; condition-specific approaches to identification (such as running lists of diagnostic codes) do not capture these factors.

To further emphasize the importance of including the patient voice in quality improvement activities, and to model the process for practices, we invited three parents to share their experiences caring for CYSHCN during our Learning Session on Care Coordination in May of 2012. These parents agreed to further participate by sharing their experiences during the Annual Tri-State Children’s Health Improvement Consortium Conference in June. The incorporation of the patient voice into our Learning Sessions was well-received by participants; This approach will be utilized in upcoming Learning Sessions.

Lastly, OPIP is currently developing a consulting contract for a parent of a child with special health care needs to join the OPIP project team facilitating the ECHO Learning Collaborative. We are grateful to OCCYSHN for partnering with us on the recruitment of this person and look forward to their leadership, guidance and wisdom on the project.
#4: Informing Policies that Support Optimal Health and Development

**Assuring Better Child Health and Development (ABCD) III**

The work of ABCD III has illuminated various issues of significance with regard to policies supporting health and development. In fact, it is likely that some of the most impactful outcomes of ABCD III are the result of addressing just such policies and systems.

- **Clarification on the billing for 96110**
  Prior to this year, DMAP enhanced policies related to the billing of the 96110 that allowed for two claims to be submitted on the same day, as the Bright Futures recommendations call for both general developmental AND Autism screening at both the 18 and 24 month visits. Clarification to plans on this rule was provided as part of ABCD III. In addition, changes in Medicare rules caused confusion amongst plans and providers regarding the reimbursement of 96110. Through ABCD III, clarification regarding the policy was provided to MCOs.

- **Early Intervention (EI) Medicaid Billing Practices**
  As part of the ABCD III chart audit process, DMAP provided lists of members currently accessing EI to each participating MCO. These lists, generated through billing data, included a surprisingly low number of children given the large populations these MCOs serve. This process, and the resulting low numbers, has illustrated a systematic issue with how EI bills Medicaid. For various reasons, EI contractors forego Medicaid billing: some because this process is viewed as overly cumbersome, some due to misconceptions about eligibility, and some due to concerns over what types of providers can actually bill Medicaid for the services provided. Another key policy issue identified is that EI can only bill Medicaid for services provided to children that are deemed *eligible* for EI services. In other words, screening and evaluation can only be paid for if the result of them is that the child is deemed eligible for services. The collection of issues described in this section are key policy issues to be followed up on and addressed in future efforts.

- **Early Intervention Data System (EcWeb) Improvements**
  In an effort to address concerns raised during the community engagement process and by numerous stakeholders, ABCD III partners at EI designed and implemented improvements to the data system used by all Oregon EI contractors:
  - *Intake script and improvements to referral fields*
The community engagement process for ABCD III revealed that how individual contractors were interpreting the definition of certain variables in the system varied. As a result, the contractors agreed on standardized definitions and an accompanying script for intake people to follow across all contractors. This process also resulted in improved intake fields with regard to referral source, and more effectively documenting primary care provider information (regardless of referral source).

- **Evaluation template and automated evaluation results summary**
  A template was created within EcWeb (available to all Oregon contractors) where all content from the evaluation could be entered. With the information entered into the system this way, it is now possible to create an automated results summary document; the contents of which were informed in part by information collected as part of ABCD III. This innovation streamlines the process for contractors, while also getting providers the type of information they need in a format that is maximally accessible.

- **Feedback tracking**
  Another feature added to EcWeb is the ability to track when feedback was sent to the primary care provider, what kind of feedback was sent, and to whom it was sent. This will allow for an improved tracking of coordination activities.

### Tri-State Children’s Health Improvement Consortium (T-CHIC) & Enhancing Child Health in Oregon (ECHO)

Both of these projects are funded through the CHIPRA demonstration grant. Therefore, the learnings from these projects are meant to inform national polices from the Centers for Medicare and Medicaid Services (CMS), related to quality measurement and improvement as well as state-level public policies. Through project-level quarterly reports to the Oregon Health Authority, and the T-CHIC semi-annual reports to CMS, a number of policy level improvements and considerations have been noted. These have been focused on:

- Policies related to enhanced reimbursement for persons with “chronic conditions” as defined by the Affordable Care Act, and how these efforts have minimized the focus on children and youth and prevention of chronic conditions, and maximal care for children with special health care needs.
- Policies related to methods used to define and identify children and youth with special health care needs.
- Policies used to define “medical home” and related payment incentives, and how to ensure a child AND family-centered focused. In Oregon, we are specifically developing a number of summary reports specifically focused on the improvement of the Patient-Centered Primary Care Homes efforts and related enhanced payments from Medicaid.
• Policy and payment considerations to support care coordination with primary care and across community-based systems serving children.
• Policies related to quality measures used at the state, system and provider-level, and implications for improvements to the measures and related processes to ensure that data collected is meaningfully used to improve care.
• Policies that can support practice-level adaptive reserve to be able to transform practice and do quality improvement and measurement activities.
• Policies that support adoption of Electronic Medical Records (EMR), tempered with an understanding about the current limitations of existing EMRs in a pediatric focus, population management, and quality measurement.

NON PROJECT-SPECIFIC ACTIVITIES FOCUSED ON INFORMING OREGON HEALTH REFORM ACTIVITIES

Participation in OHA Workgroups/Committees

The OPIP Executive Leadership continues its involvement in following state-led workgroups and committees that support the state’s health transformation efforts.

PCPCH Implementation workgroup

This workgroup was convened by the Oregon Health Authority and facilitated by the Northwest Health Foundation. The purpose of the workgroup was to examine the technical assistance needs of practices in attempting to implement the state’s PCPCH standards. The members of the group included leadership of various organizations that are currently working with practices in implementation of Medical Home standards. The workgroup convened in summer of 2011, and the end result of the recommendations of this committee was the state’s funding of the PCPCH Implementation Institute. Dr. Gillespie and Ms. Reuland both served on this committee, Ms. Reuland as an ex-officio member.

CCO Outcomes, Quality and Efficiency Metrics

The members of this workgroup were appointed by the Governor as a result of House Bill 3650, which initiated the formation of the Coordinated Care Organizations in the state of Oregon. Four workgroups convened to address various aspects of implementation. Dr. Gillespie was appointed to the Outcomes, Quality and Efficiency Metrics workgroup that convened in September of 2011. After four meetings, the workgroup’s recommendations were folded into a report submitted to the Governor’s Office in December. Among the recommendations were
that the CCOs should focus on outcome measures whenever possible and Kindergarten Readiness was advanced as a potential outcome measure for the emerging CCOs.

Tri-county Medicaid Collaborative Advisory Committee

The Tri-county Medicaid Collaborative (TCMC) represents a coordinated effort of several of the Medicaid Managed Care Organizations (MCOs) in the Portland Metropolitan area to form into a regional CCO. Dr. Gillespie participated in this Advisory Committee to bring child health expertise into the conversations about formation of a CCO. Through this Committee, Dr. Gillespie proposed that a measure framework with a life-course perspective was needed to thoroughly assess the health of the patients and of the community. It was further proposed that Maternal-Child Health expertise is vitally needed in the governance of any emerging CCO, though this is not specifically required in current CCO contract language.

Summary Briefs Developed by OPIP Leadership

In the course of working with policymakers, OPIP has created summary briefs meant to inform reform efforts within the Oregon Health Authority, the Early Learning Council, and other state agencies. These briefs were focused on the following topics:

- *Using Kindergarten Readiness as an Accountability Metric for Coordinated Care Organizations in Oregon*, December 2011.
- *Shared Accountability for Oregon’s Coordinated Care Organizations and the Early Childhood Design Team*, December 2011.

Summary Briefs by the Broader OPIP Executive Committee

The OPIP Executive Committee is intentionally comprised of public and private entities with a shared investment in child health care quality and shared goal of improving the health of the children and youth of Oregon. This engaged group meets monthly, during which highlights of key Oregon health reform activities are summarized. Through the course of these meetings, two timely summary briefs were created in collaboration with the OPIP partners, which summarize input from this broad group of stakeholders to the fast-paced health reform efforts. The summary briefs collaboratively created focused on the following:

- *Oregon Health Authority’s Patient-Centered Primary Care Homes (PCPCH) Attestation: Key Learnings from the Front Line Based on Practice Level Review*, April 2012.
- *Opportunities to Ensure a Maternal and Child Health Focus in the Coordinated Care Organizations*, April 2012.
Public Comments

The OPIP Executive Leadership also submitted public comments to the following calls for public input:

- Early Childhood Matters Advisory Committee - Early Childhood Matters indicators
- Agency for Healthcare Research and Quality, Effective Health Care Program Comment on Key Questions: Efficacy and Safety of Screening for Postpartum Depression
- Agency for Healthcare Research and Quality, Effective Health Care Program Comment on Key Questions: Interventions Addressing Child Exposure to Trauma: Part II – Trauma Other Than Child Maltreatment and Family Violence
- Pediatric Measurement Center of Excellence / Physician Consortium for Performance Improvement Public Comment on ADHD Measurement Set.
MEETINGS & PRESENTATIONS

Meetings Facilitated / Attended:

Care Coordination for Children and Youth: Ensuring a family-centered focus and synergy across care coordination efforts in Oregon - June 29th 2012: This meeting was facilitated by OPIP, with support from the Tri-State Children’s Health Improvement Consortium (T-CHIC) and attended by 45 people from various public/private entities in the state and in T-CHIC. The meeting was intended for partners to share their experiences and learn from each other about what methods work well or do not work well in effective care coordination, and to create a meaningful dialogue of how to better enhance these care coordination models for children and youth in Oregon. Keynote presentations were given by two parents of children and youth with special health care needs, and Dr. Carl Cooley from the Center for Medical Home Innovation. More information about this meeting can be found on the OPIP website.

Assuring Better Child Health and Development-III Grantee Meetings: Members from the OPIP team attended the July 2011 and January 2012 meeting of the ABCD-III grantees, and presented highlights from the ABCD III project and key learnings.

Bright Futures Preventive Services Improvement Project- October 2011: Dr. Gillespie attended this meeting as a faculty member.

Regional / National Presentations:


Gillespie RJ, Davis W. START: Screening Tools and Referral Training for Pediatric and Primary Care Practices. Postpartum Support International Annual Conference, September 2011, Seattle, WA.


Gillespie RJ. The Oregon Pediatric Improvement Partnership Story. Oregon Health & Science University, Department of Pediatrics Grand Rounds, July 2012, Portland, OR.

Webinars:

Reuland, C. Bright Futures Preventive Services Improvement Project: “Involving Families in the Quality Improvement Process.” October 2011

T-CHIC Project Team (Including Ms. Reuland). CHIPRA Demonstration Grantee Call: Approaches to identifying children with special health care needs (CSHCN): “Key learnings and Preliminary policy and practice level implications from the Tri-state Children’s Health Improvement Consortium.” April 2012
COLLABORATIONS

OPIP Executive Committee: Essential Partnership

The OPIP EC is an essential and critical component to OPIP as it ensures broad public and private stakeholder engagement and input on key issues that impact the health of children and youth in Oregon. We are honored and deeply appreciative of the OPIP EC commitment and sustained involvement.

Our Executive Committee continues to meet on a monthly basis to review project goals and progress, discuss policy developments, and identify areas of synergy between our organizations. The EC meetings are also devoted to more global issues related to the fast-paced health reform efforts and how the EC might work collaboratively to ensure that the needs of children and youth are met. The EC meetings are also a centralized place where these key stakeholders can meet, share about key activities within their own organizations, and where we can learn from each other to identify areas of synergy and collaboration.

Our current list of participating partners is:

- **Oregon Health Authority – Division of Medical Assistance Programs**: Charles Gallia, PhD
- **Oregon Health Authority – Center for Prevention & Health Promotion**: Bruce Gutelius, MD, MPH, Cate Wilcox
- **Oregon Health Authority**: Dana Hargunani, MD, MPH
- **Children’s Health Alliance**: Resa Bradeen, MD; Deborah Rumsey
- **Oregon Pediatric Society**: Arthur Jaffe, MD; Anne Stone, MA, MPA; Sandra Miller, MD; Ken Carlson, MD
- **Oregon Academy of Family Physicians**: Kerry Gonzales
- **Oregon Center for Children & Youth with Special Health Care Needs**: Marilyn Hartzell, M.Ed
- **Family Voices**: Becky Adelmann
- **Child and Adolescent Health Measurement Initiative**: Christina Bethell, PhD, MPH, MBA
- **Oregon Health & Science University**: Stacy Nicholson MD, MPH; Greg Blaschke, MD, MPH
- **Child Development and Rehabilitation Center**: Robert Nickel, MD

Over the course of the last year, the Oregon Health Authority appointed a Child Health Director, Dana Hargunani, MD, MPH to infuse Maternal Child Health expertise across the programs of the OHA. Dr. Hargunani joined our Executive Committee in winter of 2011-2012. We also had transition of three founding members of OPIP (David Willis, Sharon Fox, Katherine Bradley) due to job changes, but were fortunate to have these positions filled and their former organization’s commitment maintained. Dr. David Willis relocated to Washington DC to pursue a position directing Home Visitation programs for HRSA; Sharon Fox has resigned as the Executive Director of the Children’s Health Alliance; and Katherine Bradley transitioned from her position within the restructuring of the Department of Family Health within Oregon Health Authority. We
gratefully acknowledge the vital roles of these three founders of OPIP and will certainly miss their wisdom and participation in our organization.

National Improvement Partnership Network

OPIP is a formal partner of the National Improvement Partnership Network (NIPN). NIPN provides OPIP with an essential group of national partners to learn from and share ideas about innovate improvement and measurement strategies. OPIP staff participate in monthly NIPN calls in which strategies, tools and information is shared. OPIP has presented on three of these calls. Dr. Gillespie continues to serve on the National Improvement Partnership Network’s Leadership Team as well as the Strategic Planning Team. NIPN continues to expand its membership with new state IPs integrating into the network through the Category E work of the CHIPRA Demonstration Grants. The Strategic Planning Team developed a Strategic Plan in the fall of 2011; included in this process was a revision of the current vision and mission of the Network.

Executive Leadership and senior staff participate in the NIPN Annual Meetings and Operations Meetings for NIPN, which provide a valuable source of mentorship and ongoing support for project design and implementation. NIPN continues conversations about the development of a multi-site project centered around care coordination for patients discharged from the hospital, focused on patient-centered care plans and the transition from hospital to primary care offices.
UNMET NEEDS

Organizational Development: Due to the recent turnover in our Executive Committee staff, and limited funding to support non-project specific efforts, we have not yet conducted outreach to relevant stakeholders identified during last year’s annual report (Legacy / Emanuel Children’s Hospital, Providence / St. Vincent’s Pediatrics Department, or private health plans). There will also be a process of orienting new partners to our Executive Committee. However there have been improved connections with other QI efforts within OHSU, including the Doernbecher QI program and the general OHSU QI leadership. Establishing these contacts remains a priority for the upcoming year, as well as identifying funding mechanisms to support this broad stakeholder engagement.

OPIP Staff: OPIP currently has one position vacant (Sr. Research Associate – focus on Measurement and Evaluation). Recruitment for this position is ongoing.

Unrestricted Funding: As was noted earlier, OPIP is involved in a number of efforts to inform the health reform efforts in our state. Attendance to these committee meetings is time-intensive, yet essential. OPIP is exploring funding methods to support this kind of general, but essential policy-level work. Secondly, OPIP is exploring funding methods to support the work that is devoted to engagement of the OPIP EC, meeting facilitation, and ways in which collaboration amongst the OPIP EC partners could be enhanced and supported.

GOALS FOR THE UPCOMING YEAR

1. Continued organizational development.
   a. Extended OPIP Executive Committee to review OPIP projects and future goals, discuss role of the OPIP EC, and identify ways the OPIP EC partners can better collaborate together (scheduled for September)
   b. Semi-annual staff retreats (first retreat scheduled for October).
   c. Continued outreach to relevant stakeholders
      i. Legacy / Emanuel Children’s Hospital
      ii. Providence / St. Vincent’s Pediatrics Department

2. Complete new-hire to cover current project work / organizational chart.
   a. Fill the current Senior Research Associate job

3. If funding is identified, development of Advisory Committee to address larger stakeholder collaboration.

4. Effective dissemination of the results of our work.

5. Identification of future funding to being in late Spring/Fall of 2013.
GLOSSARY OF TERMS & ACRONYMS

**ABCD III:** Assuring Better Child Health & Development III, directed by the National Academy for State Health Policy, is a project in five states to test transformative models of care coordination. This current ABCD initiative is helping Arkansas, Illinois, Minnesota, Oklahoma, and Oregon develop integrated, community-based systems of care coordination for children.

**Affordable Care Act:** A federal statute signed into law in March 2010 as a part of the healthcare reform agenda of the Obama administration. Signed under the title of The Patient Protection and Affordable Care Act, the law included multiple provisions that would take effect over a matter of years, including the expansion of Medicaid eligibility, the establishment of health insurance exchanges and prohibiting health insurers from denying coverage due to pre-existing conditions.

**Bright Futures:** Bright Futures is a national health promotion initiative dedicated to the principle that every child deserves to be healthy and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community as partners in health practice. Launched by HRSA’s Maternal and Child Health Bureau in 1990, the Bright Futures initiative is focused at the American Academy of Pediatrics and a collaborative of other federally- and State-funded Bright Futures projects.

**CaCoon:** CAre COOrdinatioN supports public health nurses across the state of Oregon. CaCoon nurses offer home visits in which they provide families with information and skills to coordinate care for their children with complex health conditions.

**CAHMI:** Child and Adolescent Health Measurement Initiative is a national initiative that works to ensure that children, youth and families are at the center of quality measurement and improvement efforts in order to advance a high quality consumer-centered health care system.

**CAHPS:** Consumer Assessment of Healthcare Providers and Systems surveys ask consumers and patients to report on and evaluate their experiences with health care.

**CCO:** A Coordinated Care Organization is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

**CDRC:** Child Development and Rehabilitation Center serves as an education and research center for health professionals, provides interdisciplinary clinical services for persons with developmental disabilities and other special health care needs, serves as the state’s Title V Agency for children with special health needs, and supports the philosophy of partnership with families, health care providers and the community.

**Children’s Health Alliance:** The Children’s Health Alliance is an association of private practice pediatricians in the Portland, Oregon / Vancouver, Washington area. The Alliance contracts with many types of health plans, organizes and implements quality improvement initiatives focused on
children’s health care, and provides other services to assist private practice pediatricians in providing quality, cost-effective care to patients.

**CHIP:** The Children’s Health Insurance Program provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid, but can’t afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage.

**CHIPRA:** Children’s Health Insurance Program Reauthorization Act of 2009 was signed into law by President Obama in January 2009. This legislation provided states with significant new funding, new programmatic options, and a range of new incentives for covering children through Medicaid and the Children’s Health Insurance Program (CHIP). One of the goals of the legislation is to support states in developing efficient and effective strategies to identify, enroll, and retain health coverage for uninsured children who are eligible for Medicaid or CHIP but are not enrolled. CHIPRA also provided flexibility to states to expand health care coverage to children who need it, and tasked the Secretary of Health and Human Services (HHS) with developing standards by which states can measure the quality of the care that children are receiving.

**CMS:** Centers for Medicare and Medicaid Services is a US federal agency which administers Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

**Core Measures:** This refers to the initial core set of quality measures coming out of the CHIPRA legislation, for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). The Centers for Medicare and Medicaid (CMS) proposed the measures, and are asking States to voluntarily report on the CHIPRA core set.

**CYSHCN:** Children and Youth with Special Health Care Needs are define by the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as: "those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”

**DMAP:** Department of Medical Assistance Programs is the agency that administers Medicaid and the State Children’s Health Insurance Program (CHIP) in Oregon.

**Early Learning Council:** The Early Learning Council, a subdivision of the Division for Early Childhood, is tasked with guiding the efforts to integrate and streamline existing state programs in Oregon for at-risk youth and ensure all children are ready to learn when they enter kindergarten.

**EC:** Executive Committee

**ecWeb:** The data system utilized by the regional Early Intervention contractors across the state of Oregon.

**ECHO:** Enhancing Child Health in Oregon is a primary care learning community that will provide insight into the effects and learnings (successes and barriers) of implementing medical home concepts in pediatric primary care settings. This project is a portion of the Tri-state Children’s
Health Improvement Consortium (T-CHIC) project. The ECHO learning community is being facilitated in a way to allow for innovation in implementation of the core concepts and attributes of medical home in general, and as described in the elements of the Oregon Patient Centered Primary Care Home (PCPCH) Standards. The Oregon Pediatric Improvement Partnership (OPIP) is serving as the facilitator of ECHO in partnership with the Oregon Rural Practice-based Research Network (ORPRN).

**EHR**: Electronic Health Records

**EI**: Early Intervention is a system of coordinated services that promotes the child’s growth and development and supports families during the critical early years. Early intervention services to eligible children and families are federally mandated through the Individuals with Disabilities Education Act.

**EMR**: Electronic Medical Record

**EQRO**: External Quality Review Organizations. The Social Security Act requires States that operate Medicaid managed care programs to provide for an external, independent review of their managed care organizations. States may contract with an independent entity called an EQRO to conduct the external quality review.

**Family Voices**: Family Voices is a national, non-profit organization that works to ensure that families are seen as essential partners in their children’s health and well-being. Family Voices provides families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on health care.

**HRSA**: Health Resources and Services Administration, under the US Department of Health and Human Services, is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.

**IHI**: Institute for Healthcare Improvement focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations.

**IHI Primary Care Practice Coach Program**: The Institute for Healthcare Improvement Primary Care Practice Coach Program is an 11 month professional development program focused on the development of coaching skills in the technical areas of redesign content knowledge and quality improvement.

**MCO**: A Managed Care Organization is a health insurance plan that covers the services of a particular network of doctors and other providers for people enrolled in the plan.

**Medical Home**: The Medical Home Model, as developed by the American Academy of Pediatrics (AAP), is a model for delivering primary care that is accessible, continuous, comprehensive, family-
centered, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs.

**MHORT:** The Medical Home Office Report Tool is a measurement tool of the T-CHIC demonstration grant. The Medicaid Home Office Report is comprised of five modules and include validated tools such as the Pediatric Medical Home Index (MHI) and the National Committee for Quality Assurance Patient-Centered Medical Home Homes-2011 (NCQA-PCMH) as well as a number of other items from validated tools. OPIP led the development work for the T-CHIC MHORT.

**NIPN:** The National Improvement Partnership Network is a network of over 15 states that have developed Improvement Partnerships to advance quality and transform healthcare for children and their families.

**OCCYSHN:** Oregon Center for Children and Youth with Special Health Needs promotes optimal health, development and well-being of Oregon’s children and youth with special health needs

**ODS:** Oregon Dental Service is a health plan that offers medical and dental options to employers and individuals.

**OHA:** Oregon Health Authority is the organization at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. The Oregon Health Authority is overseen by the nine-member citizen Oregon Health Policy Board working towards comprehensive health and health care reform in Oregon.

**OHPR:** Oregon Health Policy and Research supports the work of the Oregon Health Authority and Oregon Health Policy Board to further health reform planning efforts and implementation in Oregon.

**Oregon Academy of Family Physicians:** The Oregon Academy of Family Physicians is the medical specialty society for family physicians in Oregon. It is affiliated with the American Academy of Family Physicians (AAFP). The mission of the Oregon Academy of Family Physicians is to advocate for family physicians and assist them in providing for the health of their patients and communities.

**Oregon Pediatric Society:** The Oregon Pediatric Society (OPS) is a non-profit, child health organization made up of 500+ Pediatricians across Oregon. The vision of OPS is to promote the optimal health and development of children and youth in partnership with their families and communities, and to support the pediatricians who care for them.

**ORPRN:** Oregon Rural Practice-based Research Network is an active clinical research network spanning rural communities throughout the state of Oregon.

**Oregon PCPCH:** Patient-Centered Primary Care Homes are clinics that have been recognized by Oregon Health Authority for their commitment to quality, coordinated care. A PCPCH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
**Performance Improvement Specialists:** Performance Improvement Specialists provide operational support for quality improvement activities at the practice level.

**PIP:** Performance Improvement Projects are performed by managed care organizations (MCO) to assess and improve processes and outcomes of care.

**QI:** Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it.

**REDCap:** Research Electronic Data CAPture is an application that allows users to build and manage online surveys and databases quickly and securely, and is currently in production use or development build-status for more than 45,200 projects with over 60,700 users spanning numerous research focus areas.

**START:** Screening Tools and Referral Training project is teaching pediatric primary care providers how to detect and manage developmental and behavioral health issues as well as maternal depression problems. START is based out of the Oregon Pediatric Society.

**T-CHIC:** The Tri-state Children’s Health Improvement Consortium (TCHIC) is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia, formed with the goal of markedly improving children’s health care quality. In February 2010, the Oregon-led consortium was awarded nearly $11.3 million over a five-year period by the Centers for Medicare & Medicaid Services (CMS) via CHIPRA Quality Demonstration Grants. Ms. Reuland, from OPIP, was part of the original team that wrote the grant that was awarded.

**TCMC:** The Tri-county Medicaid Collaborative represents a coordinated effort of several of the Medicaid Managed Care Organizations in the Portland Metropolitan area to form into a regional CCO.

**V-Code:** V codes are billing codes used to describe encounters with circumstances other than disease or injury.