Oregon Pediatric Improvement Partnership:
Opportunities to Ensure a Maternal and Child Health Focus in the Coordinated Care Organizations
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Children and pregnant women comprise approximately **65-70% of Oregon Medicaid enrollees**. Although the needs of most children and pregnant women are usually not urgent or exceedingly costly, **addressing these unique needs represent an important investment to the future health and vitality** of our communities. The Coordinated Care Organizations (CCOs) have an important responsibility to ensure that the **needs of these vulnerable populations are addressed**. Pregnant women's enrollment is normally short, with only a narrow window to address needs critical to the health of the baby and the mother that have life-long and generational impacts. **A healthy adult population results from building health capacities from early in life; healthy pregnancies and healthy children result in adult populations with fewer chronic diseases, fewer mental health challenges, and less disease burden on the health care system across the lifespan.** Maximally achieving this ideal would likely include success at accomplishing the following: (1) early enrollment of eligible children and pregnant women into Medicaid and CCOs, (2) expeditious selection of a primary care provider, (3)timely access to evidence-based preventive care and health promotion activities, (4) care coordination, and (5) access to appropriate acute care services.

The Oregon Pediatric Improvement Partnership (OPIP) is a regional collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve the quality of children's health care. **OPIP has identified a specific set of opportunities that could be considered by the Oregon Health Authority and the Coordinated Care Organizations (CCOs) in Oregon**. These opportunities fall under a set of five overarching strategies for ensuring a maternal and child health focus in the overall CCO design parameters and for consideration in the CCOs' contract language:

I. Ensure a specific focus on Maternal and Child Health (MCH) both within OHA and within the governance of the CCOs
II. Create synergy in the CCO efforts with other statewide and national efforts to improve health and wellness
III. Ensure optimal CCO data reporting for children and pregnant women
IV. Improve the current state of MCH measurement
V. Enhance the community needs assessment requirements and ensure an MCH focus

Under each strategy we have identified a set of specific opportunities to implement solutions that address MCH. We welcome discussion about these strategies and opportunities. OPIP is a resource for such public-private dialogue to improve the health of children in our state.

SPECIFIC OPPORTUNITES FOR ENSURING A MATERNAL AND CHILD HEALTH FOCUS:

I. ENSURE A SPECIFIC FOCUS ON MATERNAL AND CHILD HEALTH (MCH)

Opportunities:

a) Maternal and Child Health (MCH) expertise could be represented on the OHA *Transition Metrics and Scoring Committee* as well as any ongoing quality metrics workgroups.

b) CCOs could be guided to have MCH expertise on internal governance and quality committees.

Given that the majority of Medicaid recipients are children and pregnant women, their interests could be more intentionally represented in both the efforts of the OHA and within individual CCOs. While the prospect of "bending the cost curve" requires attention to the expensive dual eligible adult population, it is important to preserve and encourage a focus on the majority of the population that is served by Medicaid. The inclusion of MCH expertise in the governance and quality structures of both the OHA and CCOs may be a way to accomplish that.

c) CCOs could include additional expertise in Children and Youth with Special Health Needs (CYSHN).
The population of CYSHN represents an estimated 15-20% of the pediatric population, and is more likely to be enrolled in Medicaid/CHIP. The needs of this subpopulation of children and youth are unique, and should be considered at a programmatic level in each of the CCOs. If not explicitly addressed, the specific needs of this population may be lost and under identified. This subpopulation represents a particularly vulnerable group, who typically experiences difficulty with access to care, frequent transitions between hospital and primary care, and higher utilization of subspecialty and emergency care. Their care coordination needs are also unique, as they utilize services both within the health care system as well as community systems and agencies. Communication between these systems is often fragmented, causing duplications and redundancies in care as well as frustrations on the part of patients, parents and primary care providers. Additionally, this population will transition to the adult health care system and some will even become part of the dual-eligible population. Increasing access and coordination early in life will likely result in healthier adults with special health care needs (and lower costs of coordination).

II. CREATE SYNERGY IN THE CCO EFFORTS WITH OTHER STATEWIDE EFFORTS TO IMPROVE HEALTH AND WELLNESS

Opportunities:

a) Ensure synergy with current statewide efforts to improve health and wellness, as well as with existing federal requirements for the State Medicaid agency

While the CCO legislation is intended to create a more specific focus on the health of the community, the proposed structure and governance of the CCOs do not adequately ensure synergy with related

efforts within the state, nor with existing requirements at a federal level. Some specific examples where synergy could be created:

- **The Early Learning Council.** This legislation was intended to improve the early childhood systems within the state of Oregon, but does not have clear connections with the health care system despite a clear overlap of goals in early childhood health and wellness. Building the health capacity for children is required for their future kindergarten readiness and education success. At a community and population level, all children will be more ready for kindergarten when the early childhood and heath communities intentionally screen and monitor for family risk, maternal depression and parental mental health disorders while monitoring a child's developmental progression (with standardized developmental screening tools), assess and assure growth and nutrition and coordinate services for children and youth with chronic diseases. As the goals of the Early Learning Council and Pediatric health care overlap, there could be more intentional coordination of CCO activities for MCH locally, regionally and at the level of the OHA.
- **External Quality Review (EQR) Requirements.** The federal requirements specific to ensuring a state quality strategy for Medicaid recipients, performance improvement projects, and performance measures could be better leveraged. It is imperative that strategic synergy is achieved with regard to the efforts the CCOs will need to conduct in order to meet the federal requirements around the EQR. Additionally, assurance that the improvement and measurement efforts conducted through these efforts have an explicit MCH focus could be of significant value. Furthermore, components of the work could possibly be conducted by External Quality Review Organizations (EQRO) or EQRO-like entities in a way that would meet federal standards and be eligible for federal match dollars.
- **CHIPRA Reauthorization Act and Demonstration Grant Activities.** The CHIPRA legislation calls for quality measures and stratification of those measures by key subgroups, health improvement technology and electronic medical records, and provider-based models of quality improvement. As a Demonstration grantee, Oregon is currently piloting unique and important efforts that will inform the federal requirements in these areas in 2015. It is imperative that the infrastructure and learnings be developed now for the requirements that are expected. For example, the CHIPRA legislation explicitly states that quality measures will need to be stratified by CYSHN. Therefore, it would seem advantageous to ensure that the systems are built within the CCOs now for this future federal requirement.

III. ENSURE OPTIMAL CCO DATA REPORTING FOR CHILDREN, YOUTH AND PREGNANT WOMEN

Relevant Section of the CCO Administrative Rule: 410-141-3200

Opportunities:

a) Stratify OHA and CCO claims reporting by pregnant women, children, youth and adult populations. Pediatric data could be further stratified by CYSHN status. Report at OHA level and at the CCO community level.

Emergency room usage, hospital utilization, and other statistics are currently not available for children or pregnant women. Where appropriate, stratifying the claims data by these subpopulations can be an important means of identifying disparities and specific areas for improvement. Furthermore, pediatric data could also be stratified by CYSHN status, per the CHIPRA requirements that are forthcoming.

b) Categorize and report "prevention and screening services" as a percentage of total medical services.

Claims can be categorized from CPT codes into a "prevention and screening" category. The percentage of prevention and screening services relative to total medical services will serve as a baseline for both CCOs and the OHA to determine how much prevention and screening is spent relative to the total cost of health care expenditures. From this baseline, CCOs and/or OHA can track its investment in prevention and screening services.

c) Measure the Medical Loss Ratio (MLR) for the maternal, child, and adult populations for all CCOs. Report to the OHA and report publicly.

Currently each MCO reports their MLR for all of their enrollees. However, this measure does not portray the amount of revenue expended for children and pregnant women. By tracking the MLR for the sub-populations of MCH, CCOs and OHA can again identify specific areas for quality improvement for these populations.

IV. IMPROVE THE CURRENT STATE OF MCH MEASUREMENT

Relevant Section of the CCO Administrative Rule: 410-141-3200

Opportunities:

a) Adopt a Measurement Framework, include a specific MCH Focus

In order to ensure a comprehensive, parsimonious assessment of quality, selection of measures could be based on how each specific metric fits into an overall measurement strategy. The current measurement

approach does not appear to be explicitly linked to a larger quality strategy or within the larger context of a measurement framework. Rather, measures are selected from an existing list of currently collected or collectable metrics without attention to how these measures reflect an overall picture of the health of the community. Moreover, the current MCH measures are inadequate for thoroughly assessing or describing child health quality. This is a global observation about the current state of MCH quality measurement.

A measurement framework is necessary to ensure that key aspects of care are assessed and that gaps in measurement are identified; resources can then be invested in developing and testing metrics that are missing. It would seem prudent to utilize a measurement framework that is anchored to a *life course* approach, with attention to health and wellness at various stages of life (including prenatal, peripartum, infancy, early childhood, school age, adolescence, transition to adulthood), as well as attention to various health care tasks (e.g. prevention and early identification, management of acute illnesses, chronic disease management, transitions, and end of life care when appropriate). CCOs can then use this framework to inform the community assessments that will drive priority activities for their respective communities. The National Healthcare Quality Report Framework, from the Agency for Healthcare Research and Quality, identifies measures by the Consumer Information Framework and the Institute of Medicine Aims and is an example that could be used by OHA.

b) Populate the MCH Measurement Framework with a combination of claims, patient-based, and public health / population health outcome measures

Measures based on claims data are inadequate to thoroughly assess the health of a population; such measures can only accurately measure service utilization and access. There are existing state-based surveillance data sources that can be oversampled to help assess a community's health; coupled with patient experience metrics, a more complete assessment of wellness can be achieved. Examples of public health data sources that can be utilized include the Pregnancy Risk Assessment Monitoring System (PRAMS), PRAMS II, the Oregon Healthy Teens Survey, the National Survey of Children's Health, the National Survey of Children with Special Health Care Needs, and the Behavioral Risk Factor Surveillance System (BRFSS).

c) Consider Person-Centered Composite Measures that assess the comprehensiveness of care provided.

Many of the current measures are point-in-time estimates of whether a specific aspect of care was provided for a population. Person-centered measurement that would assess whether the individual received all aspects of recommended care would be valuable. An applied MCH example would be whether a child received well-child care, appropriate immunizations, developmental screening and his/her family was screened for risk factors that could impact the child's development. This person-centered approach ensures that comprehensive recommended care is provided, and that this care is

customized to the needs of the patient. Additionally, this allows an opportunity to assess gaps in what services have been provided to the patient.

d) Adopt measures focusing on population outcomes, rather than maintaining the status quo of process measures.

One of the greatest opportunities for CCOs to improve the health of the community is in establishing a focus on population outcomes rather than relying solely on the current set of process measures. Many of the proposed process measures have been used extensively and have not necessarily been shown to improve outcomes (e.g. well-child visit rates). These existing process measures should be paired with outcome measures that better reflect population wellness. An example is Kindergarten Readiness, which is an outcome measure that is correlated with a number of process measures that relate to building health capacities in early childhood (growth and nutrition, developmental screening and referral, family risk assessments, chronic disease management, and parental mental health assessments and treatment). These measures may be experimental in some cases; however, they carry the greatest potential to be transformational.

e) OHA can inform the national efforts in MCH measurement.

The current CHIPRA measures do not adequately encompass population-based health. OHA has an exciting opportunity to inform national efforts on improving MCH measurement through the lessons learned in Oregon's transformation efforts, given that Oregon is a CHIPRA Demonstration site and this is an explicit focus of the state's goals and objectives.

V. IMPROVE ASSESSING COMMUNITY NEEDS AND PERFORMANCE

Relevant Section of the CCO Administrative Rule: 410-141-3145

Opportunities:

a) Ensure community engagement as a part of each CCO's Needs Assessment process, using a proven model of engagement.

These innovative reforms provide an opportunity to ensure that the CCOs be required to engage the community in a way that has been demonstrated to be valuable in the OHA, such as the **Assuring Better Child Health and Development –III (ABCD-III) Performance Improvement Project (PIP**). These efforts have involved a three-staged engagement process that involved: 1) community cafes with patients, 2) managed care organization baseline assessments of existing policies, coupled with strategic interviews with primary care and community-based providers, and 3) community-based meeting of the respective parties (including patients) to share learnings from the needs assessment and to identify performance improvement priorities.

b) Ensure that the Community Needs Assessment/Community Advisory Council to include a specific focus on children (including CYSHN), youth, and pregnant women within the existing wording around "Critical Populations".

It is critical that pregnant women, parents of CYSHN and non-CYSHN children, and adolescents be included in the Community Needs Assessment, and that population needs assessment data be stratified by this majority sub-population. To accomplish this, these parents and adolescents could be carefully recruited to represent not only the general pediatric population, but also the population of CYSHN. Furthermore, patients (including parents of children) and providers who care for children and pregnant women (both primary care and community-based) could be required to be represented on the CCO Community Advisory Council.

c) Ensure that the Community Needs Assessment utilizes publicly available information about the health of the community.

The current language is broad enough that the CCO could conduct a Community Needs Assessment based on data already available within their systems, currently limited to claims and enrollment information. This information can be enhanced with population-based information available in the public and private sector. For example, the Department of Education and the Public Health Division have a number of data sources (e.g. Early Intervention Services, Nurse Home Visiting Evaluation, Title V statewide needs assessments, Immunization rates, etc) that would complement and enhance the Community Needs Assessment conducted by the CCO. This more robust view of the community is particularly imperative for children and youth whose prevention and developmental needs will not be identified in a narrow approach anchored to claims and enrollment information.

d) Ensure that prevention <u>and</u> developmental promotion are emphasized.

For children and youth, promotion of both health and development are essential to ensuring that the Triple Aim is achieved. Optimal health for children and youth is not simply achieved by preventing health issues from happening; rather developmental and health promotion activities must be conducted intentionally to ensure that lifelong health capacities are built. Therefore, where prevention is noted, it would seem appropriate that developmental promotion also be added to ensure that this integral component of child and adolescent health is identified.

e) Leverage Federal CMS requirements for the CCO to conduct MCH performance improvement projects.

States with Medicaid Managed Care are required to have the contracted entities conduct Performance Improvement Projects (PIP). This requirement should be leveraged within the CCO's focus on community engagement and improvement activities. Furthermore, if components of the work are

conducted by External Quality Review Organizations (EQRO) or EQRO-like entities in a way that meets federal standards than they are eligible for additional federal match dollars. Contracting with an EQRO or EQRO-like entity for the community-based engagement work can be a valuable way for the CCO benefit from an external organization facilitating engagement and needs assessment processes. This may be especially important if the EQRO or EQRO-like entity has established relationship and perceived public/private partnership interests with the engaged groups and populations. Again, Oregon has already demonstrated this process to be invaluable in the **ABCD-III PIP**.