

# Key Lessons from the National Evaluation of the CHIPRA Quality Demonstration Grant Program



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## Introduction

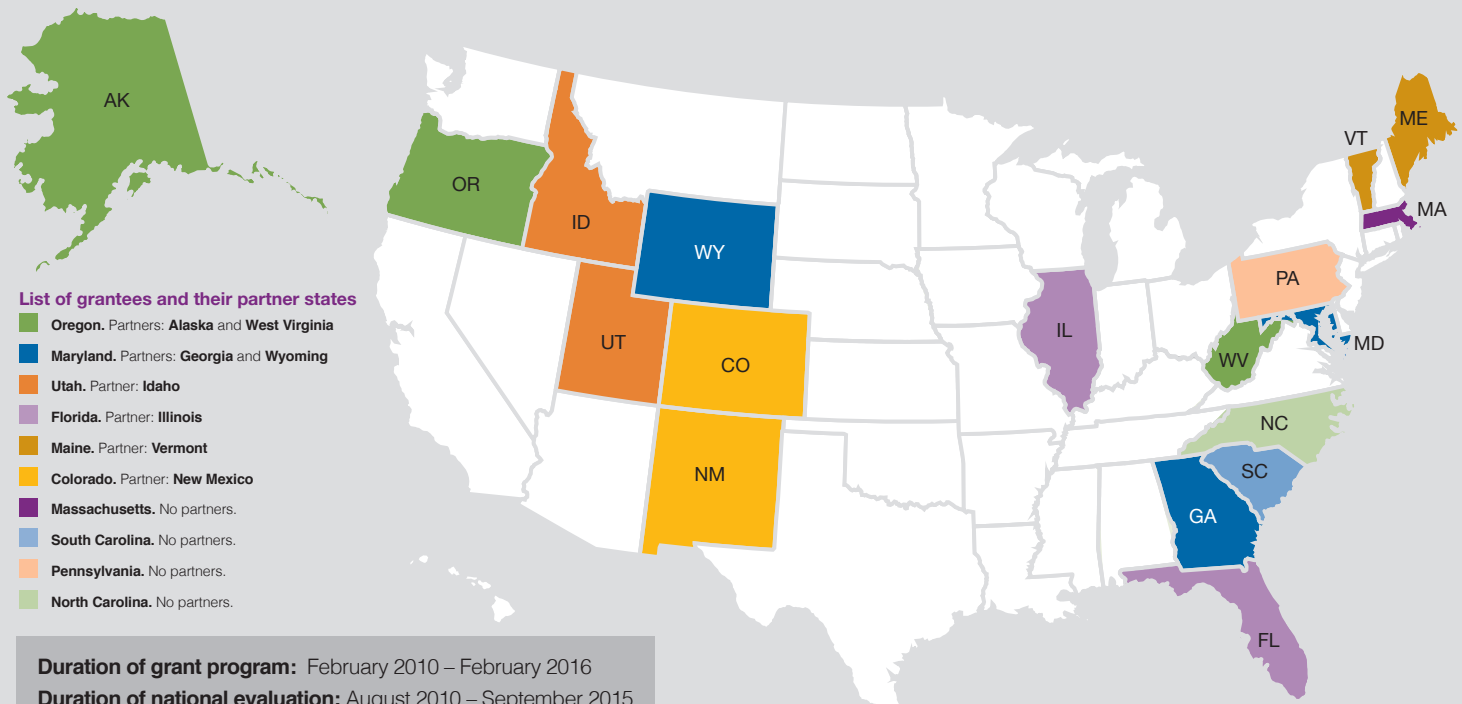
The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorized and funded the CHIPRA Quality Demonstration Grant Program to identify strategies for improving the quality of health care for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP).<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) awarded 10 demonstration grants that ranged from \$8.7 to \$11.3 million each, funding 18 States that implemented 52 separate projects. The CHIPRA quality demonstration, which ran from 2010 to 2015, was one of the nation’s largest investments of Federal dollars aimed at learning how to improve children’s health and health care.<sup>2</sup>

The national evaluation of this demonstration grant program, funded by CMS and overseen by the Agency for Healthcare Research & Quality (AHRQ), was conducted by Mathematica Policy Research and its partners, the Urban Institute and AcademyHealth. The purpose of the evaluation was to provide insights into best practices and replicable strategies for improving the quality of health care for children. (Refer to Evaluation Methods at the end of this summary for more information.)

Within the broad mandate of the CHIPRA legislation, demonstration States pursued a variety of activities, projects, and approaches. This summary,<sup>3</sup> which draws from products produced throughout the evaluation,<sup>4</sup> highlights program objectives, the strategies States used, and the lessons learned about:

- Reporting and using the core set of quality measures for children.
- Transforming service delivery to promote quality of care.
- Improving service systems for youth with serious emotional disorders.
- Applying health information technology (IT) for quality improvement (QI).
- Building partnerships to improve quality of children’s health care.
- Using Federal grants to build intellectual capital at the State level.

To illustrate some of the lessons learned, this summary includes short descriptions of selected activities implemented.



## Reporting and using the Child Core Set of quality measures

### Program objectives

CMS encourages all States to voluntarily report the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (the Child Core Set) each year.<sup>5</sup> As part of the demonstration, 10 States implemented projects involving the Child Core Set or similar quality measures.<sup>6</sup> Guided by CMS's original grant solicitation, the projects implemented by these States aimed to: (1) enhance technical capacities for accurately reporting the core measures to CMS, and (2) develop strategies for using the core measures to improve quality of care at the State, health system, or practice level.

### State strategies

To accomplish their objectives, the 10 demonstration States used varying combinations of the following strategies:

- Hiring dedicated computer programmers to develop the technical procedures needed to calculate the measures using CMS specifications.
- Developing new procedures to assemble data files from diverse sources and checking them for accuracy.
- Collecting the patient experience surveys needed to calculate certain measures.
- Establishing statewide groups to provide technical oversight and policy direction for using measures to track performance.
- Developing reports for policymakers, providers, and consumers to compare performance with national benchmarks.
- Identifying variation across practices, regions, or plans; and monitoring changes in performance over time.
- Supporting pay-for-reporting programs to encourage use of electronic health record (EHR) data for measurement.

### Lessons learned

States can substantially improve their capacity to report quality measures for children by strategically enhancing technical resources and developing methods for linking data sets. Key stakeholders within States especially value measures that can be used for QI within health systems and practices. Most States have not yet demonstrated widespread use of EHR data for calculating quality measures.

**Maine** increased the number of Child Core Set measures it reported to CMS from 14 in 2010 to 18 in 2014 through various strategies. For example, the State identified ways to use health information exchange (HIE) data to calculate measures and made other adjustments, such as adding a new billing code modifier to distinguish between global developmental and autism screenings. However, the State was unable to report on all 26 measures due to the limited availability of administrative data on behavioral health services and clinical data from practices' EHRs.

**Massachusetts** conducted interviews with practices and focus groups with families to help them design useful quality measure reports. Report production was delayed because interpreting measure specifications and developing legal agreements to access needed data took longer than expected. The State reported that its efforts ultimately yielded robust and useful reports for practices, families, and policymakers on Medicaid, CHIP, and commercially insured patients.

**North Carolina** incorporated additional child-focused measures into quarterly reports that the State makes available to all practices serving Medicaid and CHIP beneficiaries. Practices indicated that the reports helped them assess their performance and identify QI priorities. However, given delays in claims processing and infrequent reporting periods, the reports were difficult for practices to use to assess whether redesigned workflows improved care. In response, State-hired practice facilitators helped practices run supplemental reports directly from their EHRs so they could track QI changes in real-time.

Specifically, analysis of information from the projects implemented by the 10 demonstration States working in this area and from a survey of physicians fielded in several States yielded the following insights:

- Reporting capacity was influenced by a State's Medicaid data availability, technical expertise (for example, the capacity to link State data systems together), past experience with quality measurement, availability of staff time, and demand for the measures. Both the availability of the demonstration funds and substantial technical assistance from CMS allowed States to overcome some of the challenges they faced and increase the number of measures reported to CMS.
- States can use validated quality measures for children to monitor quality and compare performance across health systems and managed care plans. Policy or programmatic changes, such as stipulating benchmarks in managed care contracts and developing incentives for improvement, can be used to increase performance specifically in relation to children's health care.
- Access to fee-for-service claims data enables but does not guarantee that all administrative measures can be reported.
- Stakeholders value State reports on the performance of health plans and child-serving practices, especially when States integrate stakeholder input into report design and when States align measures across diverse reporting requirements.
- The majority of child-serving physicians receive quality reports and believe they are effective for QI, but only one-third actually use quality reports in their QI activities. Physicians in demonstration States used quality reports for QI at about the same rate as physicians in a similar state that did not have a demonstration grant.
- Lack of timely data makes it difficult for providers to use State-produced quality reports to assess efforts to improve quality. Practices need substantial technical assistance from EHR vendors and QI specialists to use their own EHR data to inform QI initiatives.
- States may not be able to produce measures that require EHR data because States and health systems have not yet developed the infrastructure needed to support data transfer from providers' EHRs. Furthermore, incomplete or inconsistent documentation in EHRs and paper charts means that practices first have to improve documentation before they can improve measure reporting.

## Transforming service delivery to promote quality of care

### Program objectives

CMS asked States to develop projects that would test new or improved provider-based models for providing health care services to children and their families. Fourteen States fielded projects in this topic area,<sup>7</sup> examining service delivery models in settings such as pediatric and family practices and school-based health centers (SBHCs).

### State strategies

To accomplish their objectives, these demonstration States used varying combinations of the following strategies:

- Learning collaboratives, including group instruction with peer-to-peer learning opportunities, in-person meetings, and web-based learning sessions.
- Intensive one-on-one support (such as technical assistance or practice facilitation) to help practices and SBHCs develop QI teams, identify QI activities, collect and analyze data (including from EHRs) to track progress, and/or improve care coordination functions.
- Addition of new staff to perform a broad set of functions related to care coordination (such as facilitating and tracking referrals or administering screening and assessment tools) and QI (such as overseeing data collection and chart reviews or creating and maintaining registries).
- Stipends or other payments to support staff time and compensate practices' loss of billable hours while working on QI activities.
- Training and certification, such as providing credit toward maintenance of certification (MOC) requirements for participation in learning activities.
- Guidance in the steps needed to obtain recognition as a patient-centered medical home (PCMH).
- Efforts to engage families in QI activities, such as financial support for parent advisors whose role was to assist practices' in their QI efforts.

### Lessons learned

To make progress in transforming service delivery systems, States will need a combination of strategies, such as learning collaboratives, direct facilitation of practice-level changes (for example, technical assistance to help practices develop performance data), and payments to practices to support staff time for implementing new QI efforts.

Specifically, analysis of the projects implemented by the 14 demonstration States working in this area yielded the following insights:

- Learning collaboratives can be a useful means for supporting practice transformation, but only when providers play major roles in selecting topics and structuring the sessions.

**South Carolina** convened a learning collaborative to help 18 child-serving practices build their QI capacity. Demonstration staff used in-person learning sessions, conference calls, and one-on-one support to help practices select, implement, and monitor QI initiatives of their choosing. Practices reported that they appreciated the flexibility to establish their own QI priorities and placed a high value on learning from other practices. As a result of their participation, practices reported using additional developmental and psychosocial screenings, providing oral health preventive services more regularly, and improving adherence to care guidelines for chronic conditions.

**Colorado** and **New Mexico** hired QI coaches and provided stipends to help SBHCs carry out QI projects. While working with the first of three cohorts of SBHCs, demonstration staff realized that supporting the SBHCs took more time and resources than anticipated. As a result, each State worked with 11 SBHCs instead of 17, as originally planned. The participating SBHCs pursued a variety of QI activities including increasing the percentage of adolescents receiving all recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and implementing new youth engagement strategies.

**Oregon, West Virginia, and Alaska** used learning collaboratives, one-on-one practice facilitation, and stipends to help a total of 21 practices enhance their medical home features. As a result, all participating practices implemented new care coordination strategies, such as routinely following up with caregivers of children who were referred for specialized care or developing condition-specific care plans. Seventeen of the 21 practices hired new care coordinators to accomplish these tasks. Practices highly valued the new care coordination staff and functions. However, many practices are concerned about sustaining them after the demonstration ends because reimbursement for care coordination services for children is not currently available.

- Practices need a variety of supports to remain engaged in learning collaboratives and other QI activities (for example, technical assistance, practice facilitators, stipends, MOC credits). States also can use web-based learning sessions to supplement or replace in-person meetings to make attendance easier, especially for practices in rural or frontier communities.
- With encouragement from the State, practices used a self-administered assessment of medical homeness that tracked changes over time and helped focus QI activities on areas most in need of attention.
- Most practices lack the technical competencies to gather the data needed to implement and track practice-level QI efforts. Although learning collaboratives can help build providers' capacity, not all practices want to improve data collection and measurement skills; some view the burden of data collection and measurement activities as outweighing the benefits.
- Some States hired practice facilitators (sometimes called QI specialists or coaches) to help practices and SBHCs develop QI teams, identify and undertake QI activities, and collect and analyze data to track progress. To be effective, practice facilitators need to: (1) possess strong interpersonal skills that support practice engagement; (2) have technical knowledge in quality measurement, QI strategies, and clinical content areas; and (3) have caseloads that permit them to spend sufficient time with a practice or SBHC.
- SBHCs may have limited experience in engaging youth in discussions about their own health and health care. States can help SBHCs by hiring youth engagement specialists who can assist in hosting workshops for youth and health literacy training for SBHC staff, and practice facilitators who can help gather and review data to inform SBHCs' clinical services.
- Developing sustainable methods for systematically engaging families and youth is challenging. For example, four States used demonstration funds to find and pay parent advisors to help practices with their QI activities but did not continue financial support for this effort after the demonstration period.
- Allowing practices to hire care coordinators directly (instead of the State hiring them centrally) better supported integration of these staff into daily operations; practices could select individuals with the credentials, demeanor, and communication style that best fit their needs and culture. States and practices raised concerns about their ability to fund care coordinator and practice facilitator positions or to continue their participation in QI activities after the demonstration grant period ends. New grant or demonstration funds or payment mechanisms that include reimbursement for care coordination and QI related activities may help practices and SBHCs sustain these activities.



# Improving service systems for youth with serious emotional disorders and their families

## Program objectives

CMS awarded demonstration grants to three States (Maryland, Georgia, and Wyoming) to improve and better coordinate the diverse services that children with serious emotional disorders and their families need to function in their homes and communities.

## State strategies

To accomplish their objectives, States used the demonstration funds to develop new care management entities (CMEs), improve existing ones, or explore methods for sustaining them. CMEs are a combined service delivery and payment model for integrating services across multiple agencies serving children with serious emotional disorders. One State used peer support training programs to help youth and caregivers develop skills needed to support other youth with serious emotional disorders and their families.

## Lessons learned

Designing or improving CMEs is a complex and lengthy undertaking. Several factors facilitate the process and help lay the foundation for strong programs. Analysis of the projects implemented by the three demonstration States working in this area yielded the following insights:

- Broad stakeholder involvement is critical to securing the cross-agency coordination and extensive youth, family, and provider involvement needed for CMEs to operate effectively. Agencies representing Medicaid, child welfare, behavioral health services, juvenile justice, social services, and education need to collaborate on the CME design process.
- Advice and assistance from experienced consultants can help States understand the array of options for designing their CMEs.
- Analyzing data on service use, cost, and eligibility from multiple agencies helps States understand how youth with serious emotional disorders received services, which in turn can inform CME design decisions. States can encounter incomplete administrative data files and difficulties in establishing interagency data-sharing agreements. Outside analysts, such as university-based researchers, can assist in the challenging task of assembling the appropriate data.
- Engaging youth, caregivers, and family advocacy groups in the curriculum development can help States create an accessible, comprehensive curriculum. Youth and caregivers who provide peer support may themselves need support if they are faced with a personal or family mental health, physical health, or other social crisis.

**Maryland** contracted with a team of researchers to analyze data submitted by the States' CMEs, as well as administrative data from Medicaid, child welfare, and the juvenile justice system. The researchers helped the State establish data-sharing agreements, reduce cross-system variation in the structure of service records, and improve data consistency. Although addressing these challenges caused delays, Maryland was able to assess the total cost of care across child-serving agencies and identify service gaps, opportunities for better care coordination, and incidences of psychotropic drug misuse or overuse. Over the long term, the State also expects to benefit from its new capacity for data analysis.

**Georgia** developed two new training curricula to prepare youth with behavioral health conditions and their caregivers to provide peer support. The State indicated that actively engaging youth and caregivers in curriculum development fostered their support for the curriculum and helped make the trainings both relevant and accessible. The State also aimed to improve access to and the quality of CME services. However, the State's ability to do so was limited by external factors, including administrative and financial changes underway in the State's Medicaid program.

**Wyoming** used the demonstration funds to pilot its first CME. Designing the CME took nearly 3 years, and the State faced several challenges including child-serving agencies' lack of prior knowledge about the model and their competing job responsibilities. Dedicating staff to leading CME development, and consulting both with a contractor and States with CME expertise, including Maryland and Georgia, helped with the design process.

## Applying health information technologies (IT) for QI

### Program objectives

CMS encouraged States to develop and enhance current health IT applications, establish links among databases, provide incentives for the adoption and use of health IT, analyze health IT data, and implement QI activities based on the analyses. Federal policymakers were looking to this demonstration to provide information on the use and impact of health IT to improve child health care quality and reduce costs, and to inform technical assistance to promote broader adoption of health IT. CMS' grant solicitation required States to coordinate with other Federal grant programs underway at the time<sup>8</sup>

### State strategies

Fourteen demonstration States implemented health IT projects,<sup>9</sup> exploring a mix of strategies for using technology to improve quality of care. Key strategies included using combinations of EHRs, personal health record (PHRs), and health information exchanges (HIEs) to support:

- Automated reporting of measures in the Child Core Set.
- EPSDT reporting.
- Clinical screening and decision support.
- Coordinating among different types of providers (especially in connection with medical homes) through secure information sharing pathways.
- Engaging consumers through patient portals and secure email.
- Adapting EHR systems to better meet the needs of child-serving practices.

### Lessons learned

Implementing health IT applications to support QI for children typically takes far longer and requires more resources than program staff anticipate. In addition, new Federal guidelines and the rapid evolution of health IT added to implementation challenges for States with projects in this area. Nonetheless, some States successfully implemented focused IT applications.

Analysis of the projects implemented by the 14 demonstration States working in this area yielded the following insights:

- Developing effective communication pathways between practices' EHRs and HIEs requires substantial resources dedicated to fixing interoperability problems, resolving privacy and other legal issues, and working closely with private IT vendors.

- Differences in EHR functionality, system incompatibility, and poor Internet connections made implementing QI projects challenging for some SBHCs. When these challenges can be overcome, SBHCs find it easier to collect and report data from their EHRs than from paper charts.
- In the process of working with contractors to develop an IT application, States must ensure that end users will actually use the application.
- Although the model EHR Format for children addresses many child-oriented functions, incorporating its requirements into current EHRs is likely to be challenging. Practice facilitators can help child-serving practices and health systems maximize the functionality of their EHRs. Getting EHR vendors to modify products to be more child-oriented, however, will continue to be very difficult because child-serving organizations represent a small share of EHR vendors' business.
- Helping States use health IT to improve quality of care may require a separate demonstration program that assembles a higher level of technical assistance than is feasible in a multi-faceted grant program.
- Projects involving the development of electronic screening methods were able to achieve their objectives and showed that:
  - Technology can streamline the administration of screening tools for health risks such as developmental delay or autism.
  - The use of electronic screening tools in practices and SBHCs can enhance documentation that services were provided and can support data quality, tracking, and monitoring and a higher quality of care.
  - Adolescents, families, and providers find electronic screening easy to use. Additionally, adolescents valued tablet-based screening as a way of communicating directly and privately with their clinicians.

**Pennsylvania**, in partnership with Children's Hospital of Philadelphia and Geisinger Health System, implemented a fully electronic screening process for developmental disabilities and other conditions. This activity contributed to improved documentation of screening and laid a foundation for more consistent and rapid referrals to early intervention programs and other resources for children with positive screens. Providers reported that the screeners are useful, though some sites have been slower to integrate them than others because of EHR limitations and competing organizational priorities.

**Utah and Idaho** laid the ground work for an interstate HIE. The States initially planned to link their individual HIEs to share public health information, such as immunization data. However, Utah's HIE development fell behind schedule as a result of vendor turnover, interoperability issues, and prolonged data sharing negotiations with provider groups. In addition, CHIPRA staff in Idaho had to work with the State's legislature to overcome privacy-related legal challenges to interstate exchange. In spite of these challenges, Utah and Idaho remained committed to sharing data, so the States investigated alternative mechanisms. Ultimately, Utah was able to use direct file transfer to send records to Idaho for more than 10,000 Idaho children who had been immunized in Utah.

Practices' use of a **Vermont** electronic registry was limited because many providers experienced difficulty in connecting their EHRs to the system, were concerned that the system required duplicative data entry, or both. In response, State-funded practice facilitators helped practices pull reports directly from practices' EHRs.

## Building partnerships to improve quality of children's health care

### Program objectives

In its solicitation for grant applications, CMS encouraged multi-State partnerships to increase the number of participating States and promote the spread of knowledge and experience.

### State strategies

Six of the demonstration grants involved multi-State partnerships involving a total of 14 States.<sup>10</sup> Partners used combinations of the following strategies to foster communication and collaboration:

- Hiring independent organizations to convene the partners and foster learning across States.
- Developing joint projects, integrating activities, and setting up complementary implementation schedules.
- Sequencing the implementation of their separate programs so the later implementers could learn from the partners that went before them.
- Pooling resources, including both expertise and funds, to co-develop QI tools and survey strategies.
- Sharing information through activities such as visiting each other's administrative offices and implementation sites, trading key materials and reports, and scheduling regular teleconferences or in-person meetings.
- Conducting mutual site visits and structured learning collaboratives for demonstration staff.

### Lessons learned

The multi-State partnerships created for this grant program led to substantial transfer of knowledge across partners with respect to specific tools for assessing quality of care and overall approaches for QI. Managing a successful partnership requires States to set aside time and resources to address challenges in scheduling meetings, coordinating site visits, and resolving conceptual differences across teams.

Analysis of the projects implemented by the 14 demonstration States involved in multi-State partnerships yielded the following insights:

- Unlike single-State grantees, States in partnerships can:
  - Combine and otherwise leverage several funding sources and build on existing efforts in each partner State to implement their projects.
  - Draw on a wider pool of resources and expertise to fill gaps in expertise and capacity.
  - Share tools and training resources.

- Apply lessons learned from each other to avoid repeating mistakes and improve the quality of their projects.
- Expand the spread and potential impact of demonstration projects.
- States are more apt to benefit from partnering when each brings complementary rather than equivalent expertise to the relationship and when they actively support each other in building key capabilities.
- Because partnering entails logistical complexities (for example, more meetings, working across time zones) State teams need to be prepared for projects to take longer to implement.
- External consultants can help overcome the challenges of administering a multi-State demonstration and realize the potential benefits of working together.

**Florida and Illinois** worked together to interpret the technical specifications for the Child Core Set and compare solutions to common data problems. Staff from Illinois also attended Florida's annual perinatal quality conference and met with its leadership to gain advice on starting a collaborative in Illinois.

## Using Federal grants to build intellectual capital at the State level

The demonstration allowed State staff and their partners to gain substantial experience, knowledge, and partnerships related to QI for children in Medicaid and CHIP—a resource we refer to as “intellectual capital.” Although the CMS solicitation did not identify this outcome as a specific objective of the grant program, all 18 demonstration States developed this resource in some fashion.

### State strategies

Specifically, the demonstration grants allowed States to build intellectual capital through one or more mechanisms, such as:

- Contracting with State universities or medical schools to develop and implement the demonstration projects, often expanding the scope of work specifications of existing contracts.
- Supporting State staff directly to develop the partnerships, inter-agency agreements, and subcontracts necessary to enhance a State’s capacity to report quality measures and implement QI activities.
- Developing new administrative entities in or closely aligned with the Medicaid agency that have specific responsibilities and authority to implement QI activities for children enrolled in Medicaid and CHIP.

### Lessons learned

Because of the demonstration, States had an opportunity to enhance their technical and administrative experience with QI initiatives for children. Analysis of information from stakeholder interviews indicates that States benefitted from this opportunity in a variety of ways:

- Having dedicated staff and resources for a 5-year period allowed most demonstration States to think about sustaining long-term strategies for improving children’s health beyond the immediate task of implementing demonstration activities. Over half of the programmatic elements that had been implemented by the end of demonstration’s 5th year had been or were likely to be sustained.
- In several States, the experience and resources developed to improve quality of care for children were subsequently applied to adult populations.
- Some States contributed substantial in-kind resources to support demonstration activities and, in doing so, worked to raise awareness about child health issues across their administrative agencies and across the State. The intellectual capital derived from the demonstration helped ensure that children and children’s health issues would be a part of broader conversations about health care payment reform and quality measurement and reporting.

In **Idaho** a new entity—the Idaho Health and Wellness Collaborative for Children (IHAWCC)—was developed to capitalize on intellectual capacity created during the demonstration. This new pediatric improvement partnership is a coalition of clinicians and stakeholders—including representatives from the State’s Medicaid program—that is invested in using measurement-based efforts to improve the quality of children’s health care. IHAWCC will use what was learned during the demonstration to continue offering learning collaboratives to enhance the QI capacity of clinicians and health care quality.

In **South Carolina**, demonstration staff will work with other State staff to transition PCMH responsibilities to a new unit in the State’s Medicaid agency (the Pediatric Quality Unit). Although this unit’s specific responsibilities are still being finalized, after the no-cost extension its staff will coordinate PCMH development and monitoring activities, as well as support QI learning collaboratives and related initiatives begun during the demonstration.

## In conclusion

The CHIPRA Quality Demonstration Grant program was an ambitious Federal effort to test promising strategies for improving quality of care for children enrolled in Medicaid and CHIP. States implemented a wide array of projects that provided many examples of those promising strategies. The national evaluation findings underscore the importance of marshaling resources over several years to enhance States' capacities to report and use quality measures, deal with challenges related to evolving Federal and State policies, address the thorny problems of implementing new health IT applications, and develop the stakeholder relationships that underpin successful efforts to transform service delivery systems.

Many elements of the demonstration programs are likely to endure because States and their partners have found additional sources of support. As Federal and State policymakers chart new directions to stimulate innovation in service delivery systems, they can look to the lessons learned from this demonstration to find promising paths to improving quality of care for children.

## Endnotes

1. Throughout this summary, the term children is used to refer to both children and adolescents.
2. No-cost extensions varying from 3 to 12 months in length were awarded to 14 of the demonstration States, thereby extending the demonstration period up to February 21, 2016.
3. The structure of this overview is similar but not identical to the five categories defined in the original legislation and grant solicitation. A description of these categories may be found at [www.ahrq.gov/chipra/demoeval/](http://www.ahrq.gov/chipra/demoeval/).
4. To obtain these products, see [www.ahrq.gov/chipra/demoeval/](http://www.ahrq.gov/chipra/demoeval/).
5. The Child Core Set includes a wide range of topics, such as access to primary care, preventive care, maternal and perinatal health, behavioral health, care of acute and chronic conditions, oral health care, and family experiences with care. For more information on the Child Core Set, visit <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.
6. Alaska, Florida, Illinois, Maine, Massachusetts, North Carolina, Oregon, Pennsylvania, South Carolina, and West Virginia.
7. Alaska, Colorado, Florida, Idaho, Illinois, Maine, Massachusetts, New Mexico, North Carolina, Oregon, South Carolina, Utah, Vermont, and West Virginia.
8. As part of their final operational plans, demonstration States were required to show how their health IT activities would be coordinated with Federal grant programs authorized under or related to the Health Information Technology for Economic and Clinical Health Act (HITECH). Such programs included the CMS Medicaid transformation grants, the Regional Extension Centers, the Beacon Program, the meaningful use initiative, and other efforts overseen by the Office of the National Coordinator (ONC).
9. Alaska, Florida, Idaho, Illinois, Maine, Oregon, Pennsylvania, South Carolina, Utah, Vermont, West Virginia, and Wyoming had projects that explicitly involved health IT; Colorado and New Mexico worked on health IT as part of other demonstration projects.
10. Two grants involved three-State partnerships: Oregon-Alaska-West Virginia and Maryland-Georgia-Wyoming. Four grants involved two-State partnerships: Utah-Idaho, Florida-Illinois, Maine-Vermont, and Colorado-New Mexico.

## Evaluation Methods

Guided by a detailed plan that specified research questions and methods for data collection and analysis, the national evaluation team gathered a substantial amount of qualitative and quantitative data about the demonstration States' projects. Qualitative data sources included program documents and reports; multiple interviews with program staff, participating practices, and other stakeholders during two rounds of site visits; and focus groups with parents in selected States. Quantitative data sources included Medicaid administrative and claims data and original survey data from physicians in selected States. Further details regarding our evaluation methods are available at [www.ahrq.gov/chipra/demoeval/](http://www.ahrq.gov/chipra/demoeval/).

## Learn More

This document represents a synthesis of findings from multiple publications, conference presentations, and webinars, which are available at AHRQ's Web site for the National Evaluation of the CHIPRA Quality Demonstration Grant Program: [www.ahrq.gov/chipra/demoeval/](http://www.ahrq.gov/chipra/demoeval/).

Specifically, this Web site includes our *Evaluation Highlights*, *Implementation Guides*, *State Spotlights*, special innovation features, conference presentations, and links to journal articles, as well as reports from participating States.



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