Factors Contributing to Sustainment Outcomes in Four States

This supplementary material contains brief case studies that examine key factors influencing decisions about sustaining elements of four states' CHIPRA Quality Demonstration Grants. The four states–Alaska, Maryland, South Carolina, and Utah— were selected as a purposive sample of the 18 demonstration states because they varied in the types of projects they implemented and the factors that influenced their sustainment decisions. The sustainment outcomes reported in this Appendix are based on evidence available as of August 31, 2015.

Alaska

In the fifth year of the grant, Alaska had implemented five potentially sustainable elements as part of its CHIPRA quality demonstration. As of August, 2015, three were or were highly likely to be sustained (Table 4). Designated staff in Alaska's Medicaid agency oversaw all demonstration work, including the hiring of consultants to implement several program elements. Alaska was part of a three-state partnership, joining Oregon and West Virginia.

Table 4. Sustainment outcomes of Alaska's demonstration elements

Demonstration element	Activity type	Outcomes
Improvements in quality measure reporting infrastructure	Quality reporting	Not sustained
Fielding the CAHPS-CG PCMH Survey	Quality reporting	Sustained
Learning collaboratives	Learning collaboratives	Sustained
PCMH QI coaching	Facilitators	Sustained
Annual payments to practices for participation in grant	Financial resources	Not sustained

Source: Analysis of data collected for the national evaluation of the CHIPRA quality demonstration grant program.

Notes:

1. See accompanying article for methods and data sources used to make determinations about whether a demonstration activity was sustained. For further description about each element, see AHRQ's website: http://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

2. Based on our standardized criteria, we excluded one demonstration activity from the list of potentially sustainable demonstration activities: Connectivity between primary care practices and the state's health information exchange (HIE). The technological links that would support such connectivity were never completed because of delays in establishing the HIE.

Although somewhat different factors influenced the sustainment outcomes of the different elements, three important cross-cutting factors were (1) the focus of the leadership team on building state-level infrastructure, (2) the institutionalization of a patient experience survey, and (3) the availability of new funding streams.

Around the midpoint of the demonstration, Alaska began planning a new quality improvement effort referred to as the Patient Centered Medical Home Initiative (PCMHI). Sponsored by several state agencies (including the Department of Health and Social Services and the Alaska Mental Health Trust Authority), and operated under a contract with the Alaska Primary Care Association, the PCMHI began in 2014, the fourth year of the CHIPRA quality grant. Because the CHIPRA grant was well known within the state's administrative agencies, the staff responsible for implementing the PCMHI reached out to CHIPRA demonstration staff for advice on structuring the new program. Demonstration staff shared knowledge gained from (1) fielding the CAHPS-CG PCMH survey (which was tested originally with practices that participated in the grant activities), (2) operating learning collaboratives, and (3) providing practices with PCMH facilitation.

As a result, under the new PCMHI, the state expanded the use of a hybrid CAHPS-CG PCMH survey[1] and offered a new series of learning collaboratives to practices across the state. In addition, practice facilitators have assisted additional practices. The state is also using the hybrid survey in its Health Resources Services Administration CYSHCN Systems Integration grant as well as a measure of access in the Alaska Access Monitoring Review Plan.

Alaska did not sustain annual payments to three practices to support participation in the CHIPRA demonstration activities. The three demonstration practices used grant-funded payments, which ranged from $110,000 to $250,000 per year, for various purposes. For example, two practices hired a care coordinator, and another focused on building its capacity to use data for quality improvement. That practice used its funds to build a robust data warehouse, which allowed it to immediately generate multiple QI reports—for example, by provider, by provider team, or by condition. The decision not to continue these payments was both logistical and financial; paying practices for QI activities was outside of Medicaid's standard operating procedures, and no additional funding streams were available. Finally, the demonstration grant funds partially supported the salary of a data analyst who helped develop practice-level data, but this position was not continued after the grant period.

Alaska is one of four demonstration states where the intellectual capital gained during the demonstration was not sustained because the staff responsible for overseeing the demonstration project did not continue to work on child health QI initiatives. However, the project did build enduring data collection infrastructures that will support future activities related to quality of care for children enrolled in Medicaid and CHIP and influenced the development of programs included in Medicaid reform legislation that was pending at the time of our data collection.

[1] Alaska implemented the CAHPS-PCMH to (1) ensure that it conducted a patient experience of care survey as part of its efforts to improve care for children, (2) provide practices applying for PCMH recognition with a survey that met relevant requirements and could inform their practice-level transformation work, and (3) assess if patients experienced improvements in processes and systems reported by the practices. The survey included additional questions of particular relevance to the state, including questions about children and youth with special needs, care coordination, and shared decision making. Hence, the state refers to the survey as a hybrid CAHPS-PCMH.

Maryland

Maryland used its CHIPRA dollars to improve the quality of and access to existing intensive care coordination and behavioral health services for children insured by Medicaid who have complex behavioral health needs.[2] To implement most of the grant's activities, the Maryland Medicaid agency contracted with the Institute for Innovation & Implementation at the University of Maryland, School of Social Work. Through this contract, the Institute employed the CHIPRA project director and other demonstration staff. Maryland was part of a three-state partnership, joining Georgia and Wyoming. In the fifth year of the demonstration, Maryland had implemented four potentially sustainable demonstration elements. As of August 2015, three were sustained and one may be sustained (Table 5).

Table 5. Sustainment outcomes of Maryland's demonstration elements

Demonstration element	Activity type	Outcomes
Revisions to service delivery and financing structure for providing intensive care coordination, mobile crisis, and peer support services for children with complex behavioral health needs	Other	Sustained
Training modules for intensive care coordination	Training, certification	Sustained
Customizations to WrapLogic, a web-based data collection, management, and feedback system	Health information technology (IT)	May be sustained
Enhanced data infrastructure to support analysis of administrative data across child-serving agencies	Other	Sustained

Source: Analysis of data collected for the national evaluation of the CHIPRA quality demonstration grant program.

Notes:
1. See accompanying journal article for methods and data sources used to make determinations about whether a demonstration activity will be sustained or not. For further information about the specifics for each element, go to AHRQ's website: http://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

2. We excluded from our analyses elements that were not designed to be sustained or were planned but never implemented. The following Maryland elements were excluded: (1) focus groups with families and youth, developed and conducted by the leadership team to assess the quality of and access to available services; (2) an analysis of psychotropic medication prescribing patterns; (3) a learning collaborative for new intensive care coordination providers; (4) site visits to and meetings with other states to learn about other CME models.

Maryland's explicit focus on improving and sustaining existing programs (as opposed to developing new, stand-alone programs) influenced the sustainment of its program elements. For example, Maryland staff developed a training module for providers of intensive care coordination to encourage and help prepare them to discuss oral and physical health needs with families. To maximize the number of providers receiving the training both during and after the demonstration, Maryland incorporated the module into the state's existing mandatory training program for providers of intensive care coordination for youth with complex behavioral health needs.

By institutionalizing several of their demonstration efforts into existing administrative functions, Maryland increased the sustainability of these elements. For instance, to facilitate data analysis across agencies, Maryland demonstration staff established new data-sharing agreements

[2] In Maryland, care management entities (CMEs) and care coordination organizations provide intensive care coordination services to children with complex behavioral health needs. These organizations aim to coordinate services provided across multiple state agencies and by multiple providers.

between child-serving agencies and helped these agencies improve data consistency and reduce cross-system variation in the structure of service records. Maintaining these institutionalized changes to existing systems will not require additional state resources above normal operating costs. Thus, Maryland can continue to draw on its increased capacity for data analysis to develop a more complete understanding of the services provided to children following the demonstration.

To develop sustainable project elements, Maryland also leveraged its implementation contractor's prior experience. Prior to the CHIPRA demonstration, several of the state's child-serving agencies contracted with the Institute to help them design and implement new services for youth with complex needs. Drawing on this experience, the Institute helped Maryland weigh options for improving services including intensive care coordination, crisis response, and family support for children with complex behavioral health needs. Ultimately, the state decided to pursue two new Medicaid State Plan Amendments (SPAs) to establish sustainable funding for and expand access to these services.[3] The Institute, using demonstration funds, drafted the SPAs and helped the state shepherd them through the federal approval process. In October 2014, CMS approved the SPAs for five years.

Unlike its other elements, Maryland's health IT element was not fully integrated into the state's existing programs or systems. For this element, the state funded the development of a state-specific version of TMS-WrapLogic, a web-based data collection, management and feedback system for providers of intensive care coordination. The state is encouraging, but not requiring, these providers to use the system following the demonstration and has not tied financial incentives or reimbursement to its use. Thus, this element may or may not be sustained depending on whether providers perceive the tool as better than other data management systems, as well as providers' resources and capacity to implement the tool.

Maryland's Medicaid agency will continue to leverage the intellectual capital gained by its implementing partner, the Institute for Innovation & Implementation. Maryland plans to continue contracting with the Institute to support program implementation and monitoring following the CHIPRA demonstration.

Overall, Maryland's implementation experience demonstrates the importance of several factors in our conceptual model. First, the sustainability of several demonstration elements was facilitated by the integration of demonstration activities within the existing infrastructure (including the state's training for providers of intensive care coordination, and improvements to data systems). Second, Maryland's demonstration effort illustrates the role implementing partners can play in sustaining efforts. The state's partner's expertise in policies for children with complex behavioral health needs influenced the development of the Medicaid SPAs—a critical pathway to financially sustaining the health care services that were the focus of this state's

[3] A Medicaid state plan is an agreement between a state and the Federal government that outlines how a state will administer its Medicaid and CHIP program. Through SPAs, states can request changes to their plan including expanding access to existing services or offering new services. States may claim Federal matching funds for services outlined in their state plan.

demonstration. Third, Maryland's experience demonstrates the benefits of building on a service model that had been tested extensively prior to the demonstration.

South Carolina

South Carolina's demonstration, known in the state as Quality through Technology and Innovation in Pediatrics (QTIP), focused primarily on developing the capacity for ongoing quality improvement in 18 primary care practices. The project team included a project director and other staff from South Carolina's Medicaid agency (the South Carolina Department of Health and Human Services, or SCDHHS), individual consultants, staff from the state's chapter of the American Academy of Pediatrics (AAP), and researchers at the Institute for Families in Society at the University of South Carolina. The team worked to assist practices with reporting quality measures, integrating behavioral health services, and achieving NCQA certification as a patient centered medical home (PCMH). In the fifth year of the grant, South Carolina had implemented six potentially sustainable elements of its program, four of which were sustained (Table 6) as of August 2015.

Table 6. Sustainment outcomes of South Carolina's demonstration elements

Demonstration element	Activity type	Outcomes
Learning collaboratives	Learning collaboratives	Sustained
Intensive technical assistance to selected practices	Facilitators	Sustained
Maintenance of certification (MOC) sponsor	Training, certification	Sustained
Certificate program in primary care behavioral health/integrated care management	Training, certification	Not sustained
Development of core measure reporting	Quality reporting	Sustained
Promotion of family involvement with primary care practices	Family engagement	Not sustained

Source: Analysis of data collected for the national evaluation of the CHIPRA quality demonstration grant program.

Notes:

1. Although promoting mental health integration was an important objective for the leadership team, we did not designate it as a separate element because this topic was covered in some manner in all of the specified elements.

2. See accompanying journal article for methods and data sources used to make determinations about whether a demonstration activity will be sustained or not. For further information about the specific activities associated with for each element, see AHRQ's website: http://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

3. We excluded the following activities from the list of potentially sustainable demonstration elements because they were no longer being implemented in the final year of the demonstration or were part of the state's evaluation activities: (1) Early work to promote enhanced payments to primary care practices for PCMH recognition, which intersected with and was eventually subsumed into a broader DHHS effort; (2) development of evaluation reports, including evaluation of enhanced reimbursements, improvement in practices' PCMH features, and changes in quality measures at the state and practice levels; (3) development of a QI registry into which practices could directly enter their QI data, which was pilot-tested but never implemented because of technical obstacles and user resistance.

Throughout the development and implementation process, the QTIP team sought to link different elements of the demonstration into a single integrated project. (This approach differed from many demonstration states, where different elements were implemented as separate projects.) As a result, the same factors affected decision-making about all the elements.

One factor that influenced sustainment outcomes involved the development of a broad-based steering committee that focused on developing sustainment plans. Within the first year of the project, the leadership team established a 15-member steering committee that included staff from

multiple state agencies and representatives from key provider and consumer organizations. The committee met every month for the first two years and then quarterly for the remaining years of the grant. Beginning in the third year of the project, the committee covered sustainability issues at each of its meetings. It also met twice for a full day (once yearly in the third and fourth years) to develop and refine a detailed sustainability plan.

Despite a change in the SCDHHS's director, the project leadership was able to maintain relatively high and positive visibility for the demonstration elements. For example, the project director created an internal newsletter describing the project's work and sent it to the agency's deputy directors. The team's inclusion of a respected pediatrician who had played major leadership roles in the state's AAP chapter garnered considerable support for QTIP from the pediatric community. This partnership facilitated SCDHHS's collaboration with the state's AAP chapter to expand MOC offerings to pediatric practices across the state after the demonstration.

Another factor influencing sustainment outcomes involved the evidence assembled to document the program's positive attributes and effects. Researchers tracked the practices' and the state's performance on core quality measures and collected data about the experiences of the 18 participating practices. QTIP staff believe that the presentation of this evidence on the perceived value and positive outcomes of the program to the director of SCDHHS substantially contributed to SCDHHS's decision to institutionalize QTIP and its mission as a new entity within the agency. This entity will build on many of the procedures developed and lessons learned during the demonstration, and will continue the learning collaboratives and technical assistance, with particular focus on integrating attention to behavioral health concerns into primary care practices. In addition, activities related to core measure reporting will continue through an existing contract with the University of South Carolina.

The project leadership also sought to align program activities with SCDHHS's broader goals. For example, in the third and fourth years of the program, the QTIP team selected topics (e.g., asthma, improving birth outcomes) for its learning collaborative to correspond with other DHHS initiatives. Through this alignment, QTIP built additional support both within DHHS and the pediatric community, making the demonstration work seem part of, rather than separate from, the state's larger agenda.

The state will not be sustaining certificate programs in primary care behavioral health (a course for mental health professionals) or integrated care management (a course for care managers in pediatric practices). Participants in these courses, which were designed to promote the integration of behavioral health care into pediatric practices, felt that they did not provide sufficient benefits for the time invested. QTIP staff therefore did not work to sustain these programs because their value was marginal and they had no designated state funds to support them.

Finally, the state will not support the element related to family engagement—an effort that paid parent partners to work with selected families in the 18 participating practices for up to 4 hours per week. QTIP developed and implemented this element in collaboration with Family Connection, a nonprofit organization that supports families of children with special needs. QTIP decided not to continue this effort because the state's Medicaid agency has no mechanism for paying such individuals and because state dollars were limited. In addition, Family Connection

received another federal grant to sustain some of this effort, which provided an additional rationale for not sustaining the effort with state funds.

The intellectual capital developed over the course of the demonstration will be sustained through the new Medicaid entity that focuses specifically on improving quality of care for children, and the continued collaboration among the state, AAP, and university researchers.

Utah

Using the demonstration grant funds, Utah's Medicaid agency used the CHIPRA demonstration funds to promote the use of health information technology (IT) and to help 12 child-serving practices implement the PCMH. The agency worked closely with the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ).[4] The grant's project director was part of UPIQ, as were many of the demonstration staff. Utah was part of a two-state partnership, joining Idaho.[5] In the fifth year of the grant, Utah had implemented seven potentially sustainable elements of its programs. As of August 2015, three were or were highly likely to be sustained; three were not sustained; and one may be sustained (Table 7).

Table 7. Sustainment outcomes of Utah's demonstration elements

Demonstration element	Activity type	Outcomes
Learning collaboratives	Learning collaboratives	Sustained
Funding for medical home coordinators in practices	Financial or labor resources	Not sustained
Development and maintenance of QI TeamSpace website	Health IT	Sustained
Development and maintenance of Medical Home Portal website	Health IT	Sustained
Pediatric patient summary (a portable medical record)	Health IT	Not sustained
Inter-state (UT-ID) exchange of immunization records	Health IT	May be sustained
Stipends for family partners	Family engagement	Not sustained

Source: Analysis of data collected for the national evaluation of the CHIPRA quality demonstration grant program.

Notes:

1. See accompanying journal article for methods and data sources used to make determinations about whether a demonstration activity will be sustained or not. For further information about the specifics for each element, see AHRQ's website: http://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

2. Based on our standardized criteria, we excluded the following demonstration activities from the list of potentially sustainable demonstration activities, since they were no longer being implemented in the final year of the demonstration or were only ever meant to be one-time activities: (1) The EHR Measure Calculator, subsequently called Practice Analytics (a centralized system designed to pull data from demonstration practices' EMRs), and (2) access for participating practices to an EMR with a message log for practices to use to improve continuity of care for children and youth with special health care needs.

The state was able to continue and extend its series of child-focused learning collaboratives by finding an organization (the University of Utah Health Plans, a managed care organization) that would provide the in-state funding used as the draw-down for a federal match available for QI projects through Medicaid administrative claiming (see http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-administrative-claiming.html). The decision to seek funds through this mechanism emerged from a recognition

[4] Formed in 2003, UPIQ is a statewide improvement partnership that brings together a broad group of stakeholders, such as clinicians, hospitals, health plans, and staff in government agencies, to identify and monitor strategies for improving the quality of care for children.

that the state would be unable, on its own, to support the learning collaboratives, which participating practices had valued highly and which the state viewed as effective in helping child-serving practices implement features of the PCMH. Consequently, the federal match provided an attractive option for sustaining this effort, assuming that in-state funds could be found. UPIQ's leadership worked closely with the state and consulted with many of the state's child-serving organizations before University of Utah Health Plans agreed to provide the funds. Overall, this effort reflects the influence of strong partnerships (in this case between the state and UPIQ and between UPIQ and other child-serving entities) and the availability of alternative sources of funds (via Medicaid administrative claiming).

Four of Utah's elements involved health IT. Their sustainment outcomes reflect a variety of factors that influence adoption of IT applications relevant to care for children. Most often, grant dollars were used for development efforts around these elements, and the demonstration leadership then sought continued funding to maintain elements perceived as useful.

First, given the rural nature of the state, the grant leadership believed that dependable access to useful web-based portals, platforms, and other IT applications would help geographically dispersed providers maintain communication and learn from each other. For example, demonstration funds supported the development of QI TeamSpace, a customizable data-entry website designed to allow practices participating in QI efforts to track their efforts over time – such as by documenting gains on small-denominator quality measures. Practices that have used this website have found it quite valuable for supporting QI efforts. Specifically, participants in learning collaboratives in Utah and staff in more than 1,000 practices who have participated in about 60 learning collaboratives in 8 states have used this website. The positive reaction to the website drove the decision to continue it, if funding for its maintenance could be found. The state indicated that it would support the website as part of its ongoing operations for a limited period of time. To help defray ongoing maintenance costs, users were asked to pay for access. The leadership of the grant expects to sustain this website, in part, through these payments and, in part, with other private or state-based funds.

Second, the medical home portal is a website that contains modules pertaining to more than 45 diagnoses. It offers information for physicians and families, posts a newsletter and blogs, and includes resources available through the state's network of care coordinators. The grant leadership decided to seek funds to sustain this website because of its broad popularity both within and outside the state. Other grants and a major hospital system are now covering the costs of the website's maintenance.

Third, grant funds supported the development and initial implementation of the pediatric patient summary (PPS), a portable medical record designed for parents of children with complex conditions. The platform was based at one of the state's largest health systems (Intermountain Medical Center) but encountered problems because it depended on the state's health information exchange (HIE) for important information. However, at that time, the state's HIE was quite limited in the amount of information available and the ease of accessing it. The grant leadership decided not to actively pursue continued support for the PPS because of the extent of these problems and because key staff at Intermountain indicated that it was not a high priority for them going forward.

Fourth, because Utah residents who live near the Idaho border may receive care in Idaho, state-level quality measures may not account for children who receive recommended immunizations in Idaho (and vice versa). To improve the accuracy of both states' immunization measures, the states worked to clear legal and technical hurdles to support data sharing between their immunization registries. Although the states were unable to achieve bidirectional exchange by August 31, 2015 (the closing date for data for this study), 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. Assuming the states move forward with bidirectional exchange, this positive sustainment outcome will illustrate the benefits of aligning project goals with broader state agency priorities (in this instance, developing accurate quality measures).

Using grant funds, the state provided stipends for "parent partners" (the family engagement element noted in the table above). These parents worked with practices to help them provide more family-centered care and to offer peer support to families of children with special health care needs. The provider community expressed mixed reactions to this program element. Some practices found parent partners to be valuable (and are compensating them using practice funds or have convinced them to stay on in a volunteer capacity); other practices faced challenges integrating parent partners into their practice. Toward the end of the grant period, the grant leadership identified a potential source of funds for this work—the state's block grant from the Maternal and Child Health Bureau in the Health Resources and Service Administration (HRSA). However, Utah judged other QI activities as more deserving of these funds, in part because of the mixed reactions from the provider community. As a result, the state did not continue support for this element.

With respect to the intellectual capital derived from the demonstration grant, Utah's state Medicaid agency has continued to work with UPIQ. This relationship pre-dated the grant and provided the context for most program activities. Experience derived from the grant has allowed the leadership to pursue new opportunities for quality improvement (QI) initiatives for the state's children.

Overall, Utah's experience and sustainment outcomes illustrate the role of several factors represented in our conceptual model: strong existing relationships among key partners, the availability of additional funding (in the form of federal and state grants, funds from implementation partners, and user fees), evidence of positive effects (as defined by high rates of website use), alignment of key elements with state priorities, and tight budgets forcing prioritization among elements.