Spotlight on West Virginia

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This brief highlights the major strategies, lessons learned, and outcomes from West Virginia's experience during the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) from February 2010 to August 2015. For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) led the evaluation of the program.

West Virginia's Goals: Improve the quality of care for children by—

- Helping practices to implement the patient-centered medical home model.
- Encouraging improvement in child-focused quality measures.
- Increasing the use of the State's Health Information Exchange.

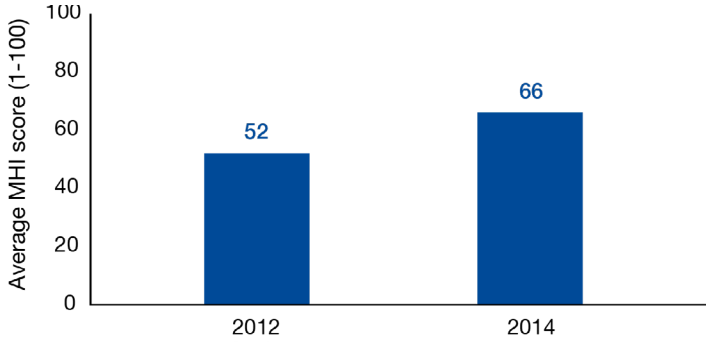
Partner States: Oregon and Alaska implemented similar projects and met quarterly with West Virginia to discuss lessons learned.

West Virginia helped child-serving practices to enhance medical home features

West Virginia helped 10 practices in rural and suburban areas to implement components of the patient-centered medical home (PCMH)—a primary care model intended to improve care coordination, access to services, and patient engagement. The State contracted with a consulting firm to teach the practices about the PCMH model and to provide a structure and a process through which practices could learn from each other in a 1.5-year learning collaborative. CHIPRA quality demonstration staff worked individually with practices to implement quality improvement (QI) activities. With this assistance, practices—

- **Enhanced the coordination of care for children and adolescents**. Practices used demonstration funding to hire care coordinators to implement new care processes. For example, care coordinators in 6 of the 10 practices called caregivers before a patient's visit to identify urgent or critical issues the caregiver wanted to discuss so that the provider was better prepared for the visit. Care coordinators also prepared caregiver education packets on topics such as obesity, connected families to community resources, and educated families on how to access specialty medical equipment. Some practices valued the care coordinators, although others found it challenging to integrate them into their practice workflows. Practices were concerned about retaining care coordinators after the grant ended because their services would not be reimbursed; however, despite these concerns, at least 6 of the 10 practices added the position as a cost to their practice and retained their care coordinators.
- **Improved population management**. Care coordinators used each practice's electronic health records (EHRs) to identify patients who needed preventive services such as immunizations, well-child visits, or follow-up care.
- **Improved performance on the Medical Home Index (MHI)** (Figure 1).[1] Although all practices worked toward becoming a medical home, a few expressed concern about sustaining this work because there is no payment tied to being recognized as a PCMH. Four of the 10 practices were recognized as PCMHs by the National Committee for Quality Assurance (NCQA); the other practices reported that obstacles to achieving recognition were the cost and paperwork required.

Figure 1. Increase in the average Medical Home Index score for participating practices in West Virginia



Note: Data were reported by West Virginia and not independently validated. MHI = Medical Home Index

West Virginia helped child-serving practices to use measures to guide their QI activities

Facilitators hired by the State helped the 10 practices not only to report on selected measures from the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) but also to use these reports to drive quality improvement.[2] The practices—

- **Reported 9 to 17 quality measures.** The State initially selected 17 of 26 Child Core Set measures for practices to report, but this proved to be more resource-intensive and challenging than expected. In response, the State asked practices to focus on reporting nine high-priority measures from their EHRs each month. Still, many practices were unable to regularly report on measures for a variety of reasons, including limited EHR capabilities to capture and report data, competing demands on the staff's and the EHR vendor's time, and a shortage of staff with expertise in health information technology. Nonetheless, practices indicated that most of the measures were useful and that they would continue to use the measures after the demonstration ended. In addition to using EHR data for reporting, the practices collected and analyzed data from a modified version of the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey—Patient Centered Medical Home (CG-CAHPS-PCMH) in order to report on the patient experience measure.[3]
- **Made changes in the delivery of care**. The State produced and sent quality reports to participating practices. The reports compared each practice's performance on reported measures with those of other practices across the State. CHIPRA quality demonstration staff helped practices use the quality reports to target their QI efforts. For example, one practice started to routinely follow up with caregivers to ensure that children received booster shots, and as a result, the practice raised its immunization rate for the booster. Two practices reported improvements in all immunization rates for 2-year-olds except for rotavirus and influenza. These practices also reported higher rates of immunizations for adolescents.

West Virginia encouraged electronic data sharing

The State initially planned to encourage electronic data sharing in two ways: (1) by connecting practices to its health information exchange (HIE), which would allow providers to exchange information electronically; and (2) by developing an electronic personal health record system that would allow caregivers to see their children's health information and to communicate with their provider electronically. The personal health record was designed to pull information from the State's HIE, but a delay in the development of the HIE prompted the State to redirect its efforts to other forms of electronic data sharing. With demonstration funds, the State—

- **Recommended that practices use a secure email platform to communicate with other providers**. Even though all demonstration practices signed up to use the platform, other providers, including hospitals and specialists, did not follow suit. Therefore, the demonstration practices could not use the platform to communicate with most referral providers.
- **Helped practices to use patient portals**. The practices started using patient portals in their EHRs to answer caregiver questions, share laboratory results, and refill prescriptions. Technical glitches in their portals and caregiver resistance to communicating with providers through the portals limited the technology's usefulness. Even so, the State noted steady progress in each practice's use of their respective portal.

Continuing Efforts in West Virginia

After West Virginia's CHIPRA quality demonstration grant ended in August 2015—

- The State Medicaid agency planned to continue regularly reporting 18 of the 24 Child Core Set measures and monitoring and evaluating the performance of managed care organizations on 4 of these measures.
- Six of the 10 practices planned to use their own funds to continue providing care coordination services.
- Several practices also planned to use their own funds to continue monitoring the Child Core Set measures.

Key demonstration takeaways

- Practices used CHIPRA quality demonstration funds to hire staff to carry out QI efforts and improve care coordination and population management. However, practices indicated that the lack of payment for both care coordination and PCMH recognition would make it difficult to sustain these efforts.
- West Virginia used a learning collaborative to help practices track selected Child Core Set measures and implement QI efforts. Despite challenges associated with generating reports on quality measures, practices used the measures to inform their QI efforts.
- Delayed implementation of the HIE limited West Virginia's ability to enhance electronic communication among providers and between providers and caregivers.

Endnotes

1. For more information on the MHI, visit http://www.ncbi.nlm.nih.gov/pubmed/12882594.
2. For more information on the Child Core Set, visit https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-core-set.pdf
3. Practices in West Virginia used a modified version of the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey—Patient Centered Medical Home (CG-CAHPS-PCMH). For more information, visit http://www.ahrq.gov/cahps/surveys-guidance/item-sets/PCMH/index.html and https://cahps.ahrq.gov/.

LEARN MORE

West Virginia's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Web site at **http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/wv.html**.

The following products highlight West Virginia's experiences—

- *Evaluation Highlight No. 2:* How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?
- *Evaluation Highlight No. 6:* How are CHIPRA quality demonstration States working together to improve the quality of health care for children?
- *Evaluation Highlight No. 9:* How are CHIPRA quality demonstration States supporting the use of care coordinators?
- *Evaluation Highlight No. 13:* How did CHIPRA quality demonstration States employ learning collaboratives to improve children's health care quality?
- *Article:* Devers K, Foster L, Brach C. Nine states' use of collaboratives to improve children's health care quality in Medicaid and CHIP. Acad Pediatr 2013; 13 (6): S95-102. PMID: 24268093. http://www.academicpedsjnl.net/article/S1876-2859(13)00100-9/pdf

The information in this brief comes from interviews conducted with staff at West Virginia agencies and at participating health care organizations and a review of project reports submitted by West Virginia to CMS.

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