

Children's Health Care Quality: Time to Grow Up?

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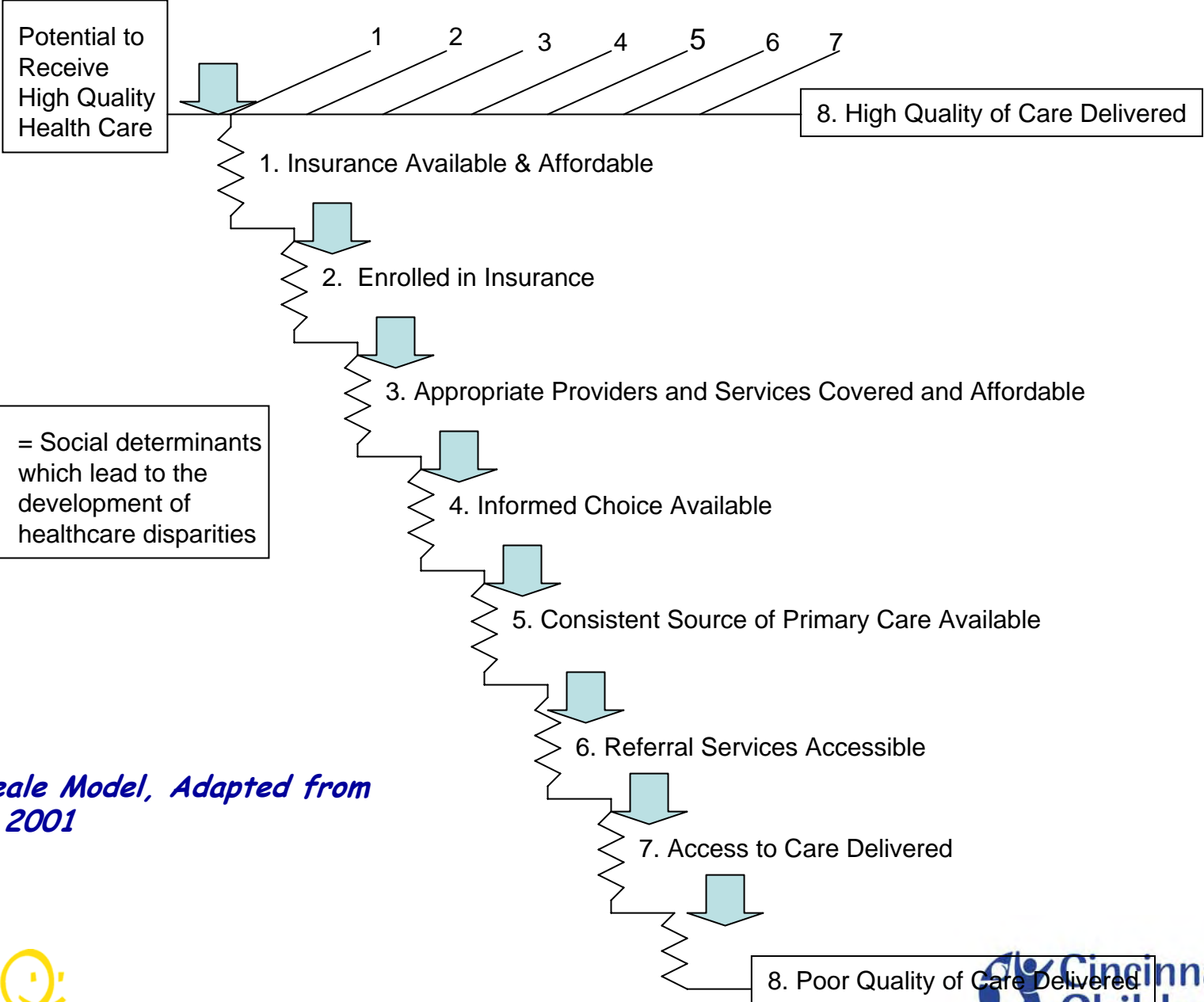
*Director, Child Policy Research Center, CCHMC
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Outline

- What is our goal?
- How are children different?
- What are the tools we need to improve quality?
- How good are the tools we have?
- What can public policy do?

Our Goal

- To improve child health
- To eliminate the gap between *what is* and *what can be* in health care for all children
- To achieve the best:
 - medical and quality of life **outcomes**
 - patient and family **experience** and
 - **value**



Simpson/Beale Model, Adapted from Eisenberg, 2001



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Children's

Aims of The Health System

- Safe
- Effective
- Efficient
- Timely
- Patient centered
- Equitable

Otherwise stated...

- The Right Care
- The Right Way
- The Right Time
- For Every Child And Family

Is quality of care for children a concern?

- YES!
- Same “Chasm” in quality for kids as for adults:
 - Safety and Errors (especially newborns, teens)
 - Effectiveness (e.g., inadequate medication for asthma, enormous variability in outcomes for cystic fibrosis)
 - Efficiency (overuse of antibiotics)
 - Equity (disparities in asthma treatment, end stage renal disease)
 - Family centered—95% children with special health care needs do not have adequate plan for transition to adulthood

Outline

- What is our goal?
- How are children different?

The “Four D’s” of Childhood & Implications for Quality

- Differential epidemiology
 - **Emphasis on prevention, growth & development**
 - **Few prevalent chronic conditions**
 - **Changes over time**
 - **Ambulatory & lower cost**
 - *lack of attention (policy, purchasers...)*
 - *low hanging fruit of measurement not possible*
- Dependency
 - **Diverse and often changing family structures**
 - *Measurement unit of analysis: child, family*
 - *Self reports vs. proxy reports*
- Developmental trajectory
 - **Rapid change in health needs**
 - *different measures at different ages & stages*
 - *need for longitudinality*
- Differential systems
 - **Heavy reliance on public systems**
 - **Links to public systems, child care, schools, WIC, healthy start, foster care**
 - *low provider reimbursements & undercapitalized practices*
 - *measurement & improvement capacity needed in multiple settings*

Adapted from Forrest, Simpson, Clancy, JAMA 1997

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- What is our goal?
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Four Types of Tools We Need

1. Evidence
2. Quality measures
3. Quality improvement strategies
4. Incentives and supports for improvement
 - Public reporting
 - Pay for P...
 - Partnerships

Evidence

- Evidence about what works in healthcare
- Evidence about the scientific soundness of quality measures
- Evidence about strategies for diffusing new information
- Evidence about the effectiveness of methods for improving quality

McGlynn, Medical Care, 2003



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Quality Measures

- “Accountability”
 - Accreditation/Certification
 - Payment (for Performance)
 - Consumer Choice
- Improvement
 - Identify gaps
 - Understand system needs
 - Track progress
- Population Health

How might it work?: Immunization

“Accountability”

Accreditation/Certification

Payment (for Performance)

Consumer Choice

License only if rates >80%

Bonus payment for each 5% above 80%

Publish rates in newspaper, let consumers choose sites

Improvement

Identify gaps

Understand system needs

Track progress

Certification

My rate is 54%-I want to improve

Reminder recall improves rates

With each change, we improve 5%

Board recertification if participate in program to track and improve

Citywide rates are X %

Population Health



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Quality Measures: Sources

- Parent/patient surveys
- Administrative/claims data
- Medical records
- Electronic health records
- State/national surveys

What Should We Measure?

- Dimensions of quality (Institute of Medicine)
 - Safe, Timely, Effective, Efficient, Equitable, Patient Centered
- Burden of illness/Costs of care
- Levels/settings
 - Ambulatory, Emergency, Hospital, Long Term Care
- Types of care
 - Acute, Preventive, Chronic Illness Management
- Perspectives on Care
 - Patient and family, technical, societal

Why do kids use health care?

- Offices/Clinics
 - Well child, respiratory infections, asthma, ADHD, Acne
- Emergency Departments
 - Respiratory infections, trauma
- Hospitals
 - Giving birth, being born, prematurity, respiratory infections, asthma, appendicitis, mental illness, trauma

What Can We Measure Now?

- **Prevention**
 - Visit rates, immunization rates, chlamydia screening
 - Timeliness prenatal care
- **Acute Care**
 - **Outpatient**
 - Appropriate treatment for URI
 - Appropriate testing for children with pharyngitis
 - **Inpatient**
 - Asthma management
 - Some newborn intensive care metrics (risk adjusted mortality)
- **Chronic care**
 - Obesity: preliminary measure (NQF)
 - Asthma (NCQA, NQF)
 - ADHD (one measure only-NCQA)
 - Experience of Care—Health Plan CAHPS (with screener)

NQF Children's Workshop, 2004

- TIER 1
 - Asthma
 - Patient safety (Inpatient)
 - CSHCN
 - Preventive Care
 - Coordination Of Care
 - Perinatal Care – Especially NICU
 - Mental Health Care
- TIER 2 – POTENTIAL PRIORITY AREAS
 - Other Acute Care – Trauma, Pain, Respiratory, Cardiovascular
 - Usual Source Of Care
- TIER 3 – MEASURES NEEDED
 - Diabetes
 - Dental
 - Obesity



Four Types of Tools We Need

1. Evidence
2. Quality measures
3. Quality improvement strategies

Quality Improvement Strategies

- Single site
 - improvement teams/projects
 - organizational transformation
- Multisite
 - Improvement collaboratives
 - Various models (e.g. Model for improvement, Lean, Six Sigma)
- Engaging Families
- HIT including:
 - Electronic health records
 - Computerized order entry
 - Clinical decision support, reminder systems
 - Registries

Children's Improvement Agenda

- Prevent Childhood **Obesity**
- Provide Seamless Evidence Based, Family Centered Care for Children with **Chronic Conditions**
- Purge **Harm** from Children's Health Care
- Promote **Equity** in Care





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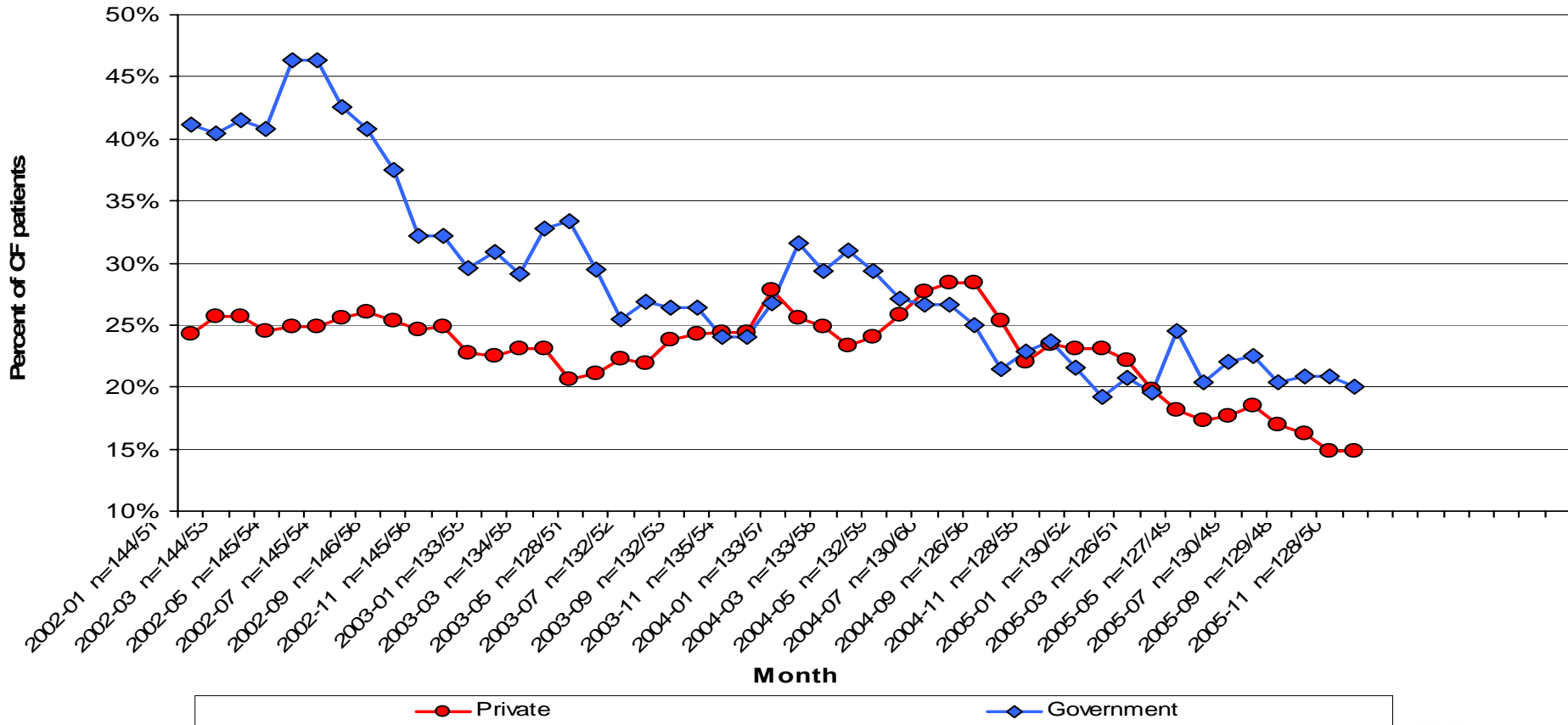




Disparities - CF



Percent of CF patients with weight for age below 10th percentile includes only patients who are less than 19 years old stratified by type of insurance



Last update: 01/03/06 by H. Atherton, Data Source: Disease Management Database



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Public Reporting

- Health plan level reporting longstanding
- Hospital level now growing
- Pediatrics often not pulled out
 - Florida
 - Texas

PP4P - Pediatric Pay for Performance

- Pay for...
 - Participation
 - Process
 - Improvement
 - Outcomes
- Growing in both public and private sector
 - >50% of all state Medicaid programs have one or more pay-for-performance programs.
 - 70% of programs operate in managed care or primary care case management (PCCM) environments, focusing on health care for children, adolescents, and women.
- Evidence of impact marginal to date, especially in kids

Improvement Partnerships

- Statewide, regional, local
- Vermont, Utah, North Carolina
- Public and private sectors
 - State medical schools
 - AAP Chapters
 - State Medicaid
- Support improvement in
 - Ambulatory practices
 - Hospitals

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Tools: A Report Card

- Evidence: less than adults, need more pediatric research funding
- Measures:
 - Sufficient measures are available in many critical areas of children's health care to get started
 - Gaps exist in important areas, e.g., trauma, mental health, medication management, oral health
 - No measurement sets for kids in widespread use

Steps from Development to Use

Individual researchers and projects

Major Developers/refiners (NCQA, RAND, CAHMI, AMA-PPMC, JCAHO, PDQs)

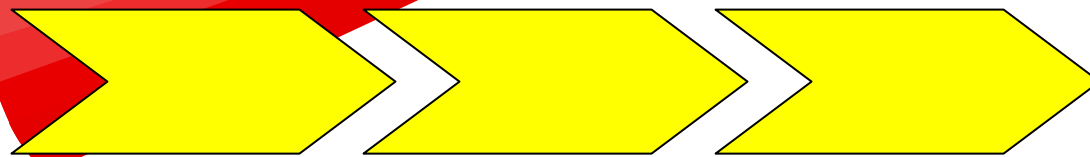
Endorsers (NQF)

Consolidators (AQA, HQA)

Mandated Use or Market Demand



Foundations, NIH, AHRQ



Purchasers (CMS, Business)

NICHQ

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Arrested Development/Blocked Pathway- Child Health Care Measures

Individual
researchers and
projects

Major
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(NCQA,
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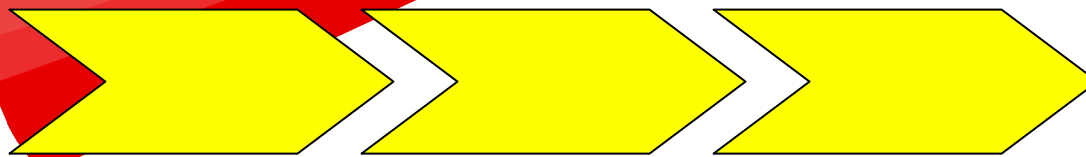
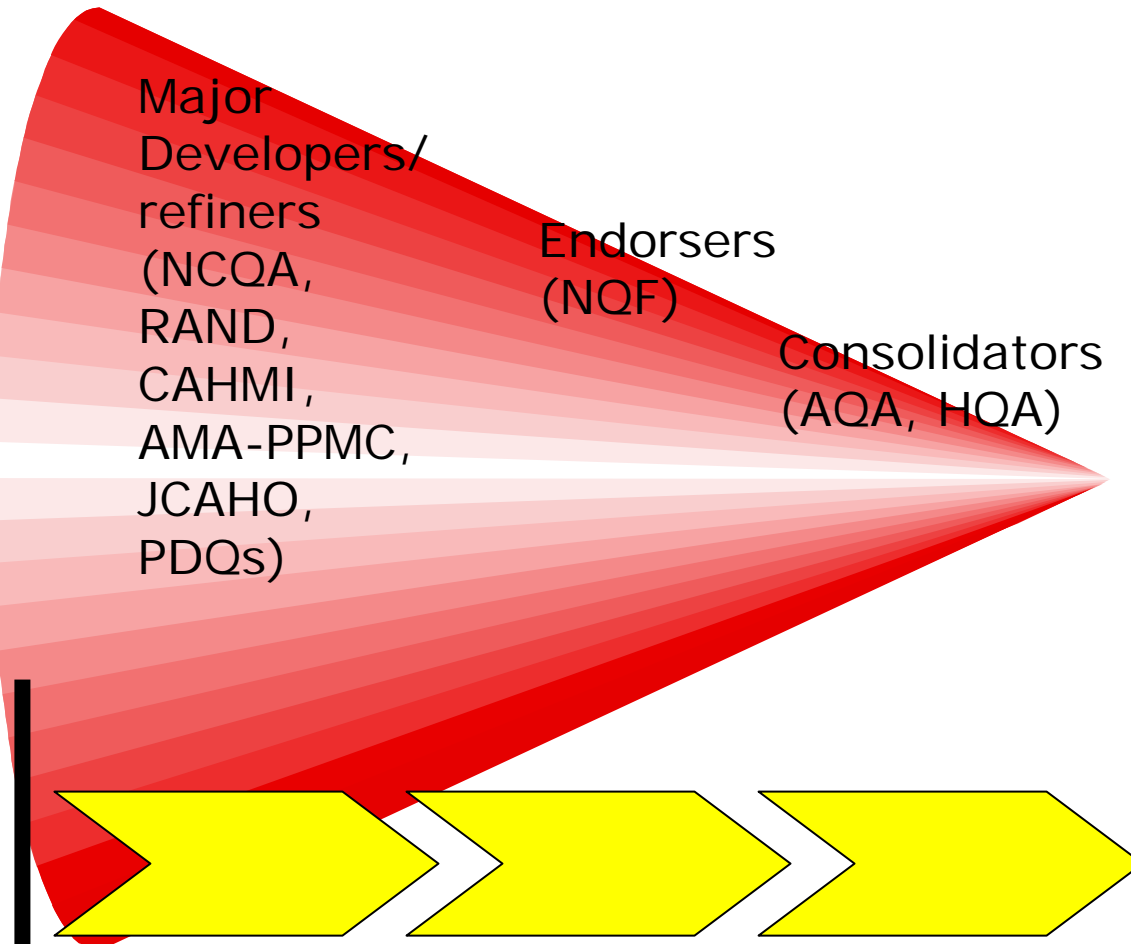
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Foundations,
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Purchasers (CMS, Business)

NICHQ

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What Do We Need?

- Move ready measures through consensus and endorsement process leading to (effectively mandated) use
- Rapid refinement, consensus and endorsement for near ready measures in specific priority areas
- Investment in development of measures in high priority areas, with commitment to move through process.

Tools: A Report Card (cont.)

- Improvement strategies
 - Spectacular successes in many sites
 - Not widespread enough
 - Low adoption EHR
 - Ambulatory: 13.7%
 - Children's hospitals: 49%
- Incentives and support for improvement
 - Growing recognition of need for infrastructure
 - Need for both public and private investments

Key Point

*While by no means perfect,
we have sufficient tools to
significantly accelerate
improvement in children's health
care quality!*

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Public Policy Actions

- Strengthen child health quality improvement activities at HHS
- Dissemination of health quality information
- Development, endorsement, and updating of child-specific health quality measures
- Demonstration grants on quality and HIT
- Federal matching rate for necessary computer system modifications
- Development of a model electronic health record for children

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Questions?

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