The National Evaluation of the
CHIPRA Quality Demonstration Grant Program

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The CHIPRA Quality Demonstration Grant Program

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded 10 grants, funding 18 States, to improve the quality of health care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

The 18 CHIPRA quality demonstration States are implementing 52 projects in five general categories:

- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The CHIPRA quality demonstration began on February 22, 2010, and will conclude on February 21, 2015. The national evaluation of this demonstration started on August 8, 2010, and will be completed by September 8, 2015.

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How are CHIPRA quality demonstration States working together to improve the quality of health care for children?

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This *Evaluation Highlight* is the sixth in a series that presents descriptive and analytic findings from the national evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstration Grant Program. Of the 10 grantees that received awards, six represent multi-State partnerships involving 14 of the 18 CHIPRA quality demonstration States. This *Highlight* illustrates how States are using the partnerships to improve the quality of children's health care. It describes the strategies that States are using to create and maintain cross-State relationships, as well as the benefits and challenges of partnering. Our analysis covers the first 3 years of these 5-year CHIPRA quality demonstration projects, including a year of planning.

KEY MESSAGES

The early experiences of multi-State partnerships in the CHIPRA quality demonstration may be useful to other States pursuing cross-State partnerships for children's health or other purposes.

- All State partners routinely share information and coordinate activities through regular meetings. Several States have collaborated more closely with their partners on at least some aspects of their demonstrations by developing joint projects, integrating activities, and setting up complementary implementation schedules.
- To support their joint efforts, States use a mix of strategies, including hosting all-partner conferences, visiting each other's sites, sharing materials, and developing formal learning collaboratives.
- States that are coordinating their work and collaborating intensively have reaped benefits that extend well beyond information sharing. For instance, they can draw on a wider pool of resources and expertise and apply lessons learned from each other to improve the quality of their projects.
- Most States noted that the benefits of partnering outweigh the costs, but working together is both time- and labor-intensive. Some partnerships have contracted with an external organization to facilitate cross-State work.

Background

The solicitation for CHIPRA quality demonstration grants encouraged States to submit joint applications for three reasons:

1. To broaden the spread and impact of the demonstration program.
2. To increase efficiency by having States build the infrastructure for quality improvement through small partnerships rather than individually.
3. To promote more diversity in the demonstration projects and ultimately yield richer, more useful information about quality improvement activities.[1]

Six of the 10 grantees formed partnerships when applying for a CHIPRA quality demonstration grant.[2] Two are three-State partnerships, and four are two-State partnerships. Through these arrangements, the partnerships are implementing a variety of projects to improve the quality of health care delivered to children, including using a core set of pediatric quality measures, promoting the exchange of information on children's health, and implementing provider-based models of service delivery, such as the medical home model of care.

Four of the six partnerships arose out of shared interests among States or experience collaborating on issues affecting children's health. Colorado and New Mexico as well as Maine and Vermont have a history of partnering. Utah reached out to Idaho to build synergies across State lines because so many children who live in Idaho receive health services in Utah. Oregon cast a wide net in its search for partners that share its interest in medical homes and quality measurement, ultimately joining forces with Alaska and West Virginia.

The other two partnerships were initiated by nongovernment organizations. Florida and Illinois are working with a research consulting firm, and Maryland and its partner States are working with a nonprofit health policy center. These organizations initially supported the States in conceptualizing and writing their grant proposals. In both cases, the grantee States have contracts with the nongovernment entities to provide continued support and consultation to the partnerships as they implement projects funded through the grant.

For this *Highlight*, the national evaluation team drew information primarily from semi-structured, in-person interviews conducted in the spring and summer of 2012. We interviewed each State's demonstration team, the staff implementing the demonstration projects, and other stakeholders. We also examined the States' final operational plans and semiannual progress reports.

Findings

All partners cooperate; several have pursued more robust collaboration

We found variation both within and across partnerships in terms of how the States are working together to implement their demonstration projects. Based on our findings, we have characterized the partners' relationships as cooperative, coordinated, and/or collaborative.[3]

All partners *cooperate* in some manner, usually by agreeing to share information on a regular basis. In addition, all States *coordinate* at least some activities with their partners through regular meetings in which they identify lessons learned from their separate experiences. A subset of these States *collaborate* with their partners by developing joint projects, aligning their activities, and implementing their projects on schedules that dovetail with one another.

We also observed that although partners may collaborate on a specific aspect of their CHIPRA quality demonstration project, other aspects of their work may be better described as cooperative and/or coordinated.

All multi-State partners are coordinating their work to learn from each other. States that are implementing similar quality improvement projects often coordinate their work very deliberately, even if they are using different implementation methods. They not only share information but also apply what they learn from each other to their own projects. For example, Florida and Illinois coordinated their quality measurement efforts by working together to interpret the technical specifications for CMS's core set of children's health care quality measures, compare these measures to their existing measurement processes, and share solutions to common data collection problems.

Cooperation and coordination between Florida and Illinois have been supported by an organization that provides project management and technical assistance. For instance, the organization has facilitated cross-State work by looking for opportunities to transfer knowledge and skills from one partner to the other. Both States have found this arrangement to be particularly helpful because they worked together very little before the grant, are geographically distant, and have different health systems, information systems, and political contexts. Each State also serves a different population.

In-person conferences, in which States share their experiences, are a common strategy for coordinating their work. Most grantees host at least one in-person cross-State conference annually, and the States in one partnership meet quarterly.

> "We really try to share, twice a year, where there is overlap, where we can learn from each other, where we can do things together, and where there are synergies."
>
> — Vermont External Stakeholder, July 2012

Several multi-State partners are collaborating to implement joint quality improvement projects. Although all States have interacted intensively with their partners at some points in the demonstration, the States in four partnerships have closely aligned their work and planned to implement the same quality improvement projects in the same way across partner States. These efforts are examples of robust, sustained collaboration.

Oregon, Alaska, and West Virginia are defining and implementing a joint medical home demonstration. Maryland, Georgia, and Wyoming are establishing or enhancing statewide care management entities.[4] Both three-State partnerships conceptualize their work as a "learning collaborative" through which they deliberately structure and align their activities to promote collective learning, planning, and problem solving. Both collaboratives include regular teleconferences, in-person conferences, and presentations that highlight their individual work and what they can bring to the others' activities.

> "The Learning Collaborative provides a structure and process by which the three States [Oregon-Alaska-West Virginia] can reach consensus, share learning and insights across [project areas], and identify opportunities to create synergy by cross-fertilization of best practices and lessons learned."
>
> — Oregon Demonstration Progress Report, February 2013

Utah and Idaho conceptualize their cross-State demonstration as one project being implemented similarly in two States. They intentionally delayed Idaho's implementation so that it could leverage the lessons learned from Utah's early experience. The two States share decisions about design issues and address implementation challenges together. During Idaho's first year of work establishing its Improvement Partnership (IP),[5] for example, CHIPRA quality demonstration staff met regularly with their counterparts in Utah to plan and make decisions about the structure and objectives of the nascent IP and to design Idaho's first learning collaborative for practices.

In the long term, Utah and Idaho envision a joint regional IP network that extends beyond the timeframe of the grant and offers cross-State quality improvement activities geared toward pediatric primary care practices. The two States are also collaborating to implement a joint medical home demonstration and to develop the infrastructure and policies that support the transmission of health information between States. To sustain this close collaboration, project directors and implementation staff regularly communicate and travel across State lines.

Colorado and New Mexico are collaborating to enhance the medical home characteristics of school-based health centers (SBHCs). The States' implementation teams meet regularly, solve problems together, and participate in the same local evaluation. CHIPRA quality demonstration staff in the two States also visited each other's sites to compare approaches, share tools, and collectively solve the problems faced by SBHCs in providing integrated primary and behavioral health care services.

> "New Mexico and Colorado are approaching implementation more similarly than differently. We do almost everything the same in terms of our implementation teams."
>
> — Colorado Demonstration Staff, April 2012

Partnering States realize tangible benefits beyond information sharing

Partnerships at any level bring some tangible benefits to the implementation process by allowing the States to bridge gaps in each other's expertise, capacity, tools, and training resources. Some partnerships include States with relatively equal levels of quality improvement experience and capacity. In other partnerships, there is a mix of experience, so one State typically mentors another. Still other partnerships include States with complementary expertise.

States use partnerships to fill gaps in expertise and capacity. When States come together, partners invariably have differing levels and types of staff expertise and capacity, and partnerships can use these differences advantageously to facilitate project implementation and quality.

For example, the partnership between Maryland, Wyoming, and Georgia joins three types of expertise that make it possible to provide comprehensive services to children and youth with severe behavioral disorders. Maryland has the most experience with care management entities and mentors its partners on the topic; Wyoming is proficient in managing psychotropic medications; and Georgia extends the partnership's capacity to operate peer-support programs.

> "It's really useful to take the time to work with another State and hear its lessons learned. Working with the collaborative has been priceless. We got information we just wouldn't have had access to, and it would have taken us a lot of work to get to the same place. Collaborating with these other States has saved us years and years of lessons learned."
>
> — Wyoming Demonstration Staff, August 2013

New Mexico and Colorado also bring complementary expertise to their partnership. New Mexico has long operated SBHCs and provides guidance to Colorado on SBHC operation and data collection. Colorado, on the other hand, has more medical home experience and is helping New Mexico enhance the "medical homeness" of SBHCs.[6]

Partners can also be "staff extenders," filling the gaps in each other's expertise and filling in for each other in times of need. Staff in Vermont, Utah, and Oregon have presented at each other's learning collaboratives for practices, and a stakeholder in Florida presented to the Illinois project team on how to establish a governance structure for its growing statewide perinatal collaborative. Illinois is also using a pediatrician on Florida's staff with expertise in asthma-related quality improvement activities as an advisor to its medical home asthma initiative.

> "There aren't a lot of human resources, so whatever we can do to utilize each other's talent is good."
>
> — Maine Demonstration Staff, July 2012

States also helped their partners when unanticipated needs arose. For example, when Idaho lost its project manager early in the grant period, Utah's medical director stepped in to assist in the hiring process. Similarly, a Colorado team member with clinical expertise stepped up to the plate when the New Mexico team's clinical expert retired.

Partners share tools and training resources. Many States are taking advantage of the tools and training resources developed by their partners before the demonstration. West Virginia shared examples of its care coordination plans and training documents, and its partners, Oregon and Alaska, are making use of this information to define care coordination functions appropriate to their contexts.

Vermont is using its substantial experience with IPs to mentor Maine. It shared materials, including a "how-to" guide on establishing an IP, that have been instrumental to the successful implementation of Maine's project. Maine also leveraged its relationship with Vermont to gain feedback from the coauthors of the American Academy of Pediatrics' original Bright Futures™ well-child visit forms when it developed customized versions to better suit the unique needs of Maine providers.

Practice facilitators in Idaho are using materials developed by Utah and are participating in Webinar trainings led by Utah's quality improvement program manager. The Colorado and New Mexico teams also have shared tools. For example, before the CHIPRA quality demonstration, New Mexico used a hard copy screening tool for adolescents. Both States have since adapted the tool and deployed it electronically across SBHC sites.

Despite its benefits, working together is challenging

All multi-State partners have put in extra time and energy to coordinate their efforts and make decisions that require input from all States. Staff in several partnerships also noted the complexities related to scheduling meetings—across time zones in some cases—and the challenge of having to attend more meetings than they would have attended were they to "go it alone."

> "It takes some effort to pull off a multi-State project. It is another layer of energy and work that a single State grantee doesn't have to do."
>
> — Alaska Demonstration Staff, May 2012

Having anticipated the challenges of administering a multi-State demonstration, four partnerships hired consultants or consulting organizations specifically to facilitate their cross-State work. These consultants managed in-person conferences and, in one case, developed a formal cross-State learning collaborative. The States found consultants to be useful in fostering and maintaining collaboration, leaving State staff to concentrate on developing effective projects.

All States reported that establishing and maintaining contracts and agreements between their respective governments has been a challenging aspect of working together, a challenge that has often resulted in implementation delays. For example, Florida and Illinois have faced delays because Florida does not have a mechanism for sending CHIPRA grant funds to Illinois to support its partnership activities.

To mitigate this challenge, Florida distributes grant funds through the consulting organization, which in turn provides project management and support to both States.

> "[The consulting organization] serves as a third-party neutral group that brings us together for meetings, provides technical assistance Webinars, and arranges site visits. . . . [Having the organization] organize all the collaborative efforts allows me to focus on my responsibility to CMS and on work happening specifically in my State."
>
> — Maryland Demonstration Staff, May 2012

Conclusion

As the Nation continues to reform its health care delivery and payment systems, States may increasingly find themselves in situations that encourage them to build relationships across State lines—or between counties or regions within a State—in order to leverage each other's experience and resources. Thus far, the CHIPRA quality demonstration has shown that given the opportunity, States can come together to develop and test innovative approaches to improving the quality of health care for children.

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. States that allocated a realistic amount of time and resources to partnering have been more likely to realize the potential benefits of working together.

Grantees that formed partnerships are experiencing benefits not available to single-State grantees. For instance, cooperation, coordination, and collaboration have substantially enhanced project implementation. The partnerships have also expanded the spread and potential impact of the demonstration.

Implications

The early experiences of the six CHIPRA quality demonstration partnerships suggest the following lessons for other States considering or pursuing partnerships to improve children's health care:

- Organize work with other States around compelling and shared goals because partnering requires time and effort.
- Aim to build relationships at an intensity that is consistent with collective goals. If the partnering objective is information sharing, choose partners with similar interests and *cooperate* through informal channels. If States want to apply what they learn from each other, choose partners that are implementing a similar project and *coordinate* around common issues. If the goal is to collectively plan, make decisions, and solve problems, States should choose partners that are willing to formalize their relationship and *collaborate* on a joint project.
- Seek States with complementary expertise so that the partnership is mutually beneficial.
- Use partnering strategies that support the type of relationship desired. States are likely to succeed in information sharing through activities like teleconferences and annual in-person meetings. Higher level collaboration may require more resource-intensive strategies, including structured learning collaboratives or expert facilitation.
- Allocate sufficient time and resources for cross-partner project management and coordination, either internally or via an outside consultant or consulting organization.
- Be prepared for project activities to take a bit longer than they might if a State were "going it alone," especially with regard to financing, reporting, and decisionmaking.

Endnotes

1. Personal communication, July 26, 2013, with CMS staff Karen LLanos, Elizabeth Hill, Lekisha Daniel-Robinson, and Barbara Daily.
2. For further details on the makeup and demonstration activities of the six multi-State grantees, see http://www.ahrq.gov/policymakers/chipra/demoeval/resources/supplhighlight06.html
3. Bailey D, Koney K. Strategic Alliances Among Health and Human Services Organizations: From Affiliations to Consolidations. Thousand Oaks, CA: Sage Publications; 2000.
4. Ferry G, Swinburn A, Foster L. Designing care management entities for children and youth with complex behavioral health needs: an introductory guide for states (forthcoming, 2014).
5. An Improvement Partnership (IP) is a durable State or regional collaboration of public and private partners that uses the science of quality improvement and a systems approach to change health care infrastructure and practice. For additional information, see the National Improvement Partnership Network (NIPN) Web site at www.nipn.org.
6. For additional details on how these States are supporting school-based health centers, see http://www.ahrq.gov/policymakers/chipra/demoeval/resources/highlight03.html.

LEARN MORE

Supplemental resources for this *Evaluation Highlight*, including further details on the makeup and demonstration activities of the six multi-State partnerships, are available at: http://www.ahrq.gov/policymakers/chipra/demoeval/resources/supplhighlight06.html

Additional information about the national evaluation and the CHIPRA Quality Demonstration Grant Program is available at http://www.ahrq.gov/chipra/demoeval/.

Use the tabs and information boxes on the Web page to:

- Find out about the 52 projects being implemented in 18 demonstration States.
- Get an overview of projects in each of the five grant categories.
- View reports that the national evaluation team and the State-specific evaluation teams have produced on specific evaluation topics and questions.
- Learn more about the national evaluation, including the objectives, evaluation design, and methods.
- Sign up for email updates from the national evaluation team.

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