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QUALITY COMMUNITY MANAGED CARE

A Guide for QUALITY ASSURANCE MEASURES for CHILDREN with SPECIAL HEALTH CARE NEEDS

Includes Pertinent Measures from Medicaid HEDIS

INTRODUCTION

Recent changes in health care financing have led to an increase in the number of children with special health care needs (CSHCN) entering managed care plans, many of which have had little experience managing the care of children with complex medical needs. As CSHCN may be at heightened risk in this environment, effective and ongoing mechanisms for quality assurance (QA) are key to assuring that managed care systems reach, appropriately serve, and improve the health of CSHCN. Measures of service delivery for CSHCN under managed care must be integrated with appropriate population based health status and health outcome measures to create a uniform set of data that allows public officials, providers, and consumers to evaluate system performance. Before we can discuss quality assurance measures for children with special health care needs, we need to define both QA and CSHCN.

Children with special health care needs, as defined by the Maternal and Child Health Bureau's (MCHB) Division of Services for Children with Special Health Care Needs, are

Children with special health care needs are those who have or are at an increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of type or amount beyond that required by children generally.

Quality assurance (QA) can be defined as the collection of relevant data for monitoring health outcomes and access to care and for identifying vulnerable populations and gaps in services. Ideally, managed care health systems improve access to health care for all persons, assure the quality of care provided, and produce cost savings. Although managed care plans are embracing quality assurance measures and are making some data available to consumers; existing standards of quality do not address the complex medical, educational, and psychosocial needs of CSHCN and their families. Issues such as continuity of care, comprehensive services, coordination across programs, and access to all levels of care are critical to the delivery of care for CSHCN at the community level.

While state CSHCN programs have long had a role in developing and monitoring standards of care, including credentialing providers, most of these programs have not implemented data systems capable of generating measures of quality. Traditionally, these programs have collected client-specific information on utilization of services paid for by the agency. The types of managed care are also varied (e.g., HMO, PPO, PCCM), and no uniform dataset exists across or within any of these types of managed care arrangements.

Most quality measures related to children concern preventative care compliance and immunization schedules. Beyond asthma measures, there are relatively few quality performance measures for children with special needs, in part because most of these conditions are relatively rare and individual health plans may have few CSHCN enrollees, and because norms for appropriate care for chronic conditions are often poorly defined, making it difficult to monitor quality of care. Relatively small numbers of enrollees can limit the statistical power of the performance measures. In addition, children with a chronic health condition are more likely to have multiple other health needs and use an array of services and physicians that often focus on the chronic condition rather than the full range of services required. One of the major challenges for state programs is to address both their own needs and those of the providers in a real-world setting. The transition to managed care for the general Medicaid population presents numerous issues to be addressed by the providers and the purchasers. This same transition for the CSHCN population presents additional challenges.

ABOUT THE QUALITY COMMUNITY MANAGED CARE (QCMC) PROJECT

Quality Community Managed Care (QCMC) for children with special health care needs (CSHCN) is a project funded by a grant from the federal Maternal and Child Health Bureau (MCHB). This project is developing a quality assurance model that addresses the needs of CSHCN, captures information from providers, involves a partnership among providers, consumers, and programs, collects the appropriate data, and provides a process for joint review by all parties. The *QCMC* project is examining the use of both qualitative and quantitative data from a number of sources, including local contracted managed care entities, local providers, and families with CSHCN. The details of these efforts are described below.

At the project's beginning, project staff conducted an extensive literature review and collected existing standards, guidelines, and procedures from professional organizations, Title V-supported centers, advocacy organizations, and state and national agencies. Staff also reviewed accepted primary care standards such as those published by the American Academy of Pediatrics (AAP), Medicaid's Early Periodic Screening, Diagnostic, and treatment (EPSDT) program, and dental practice parameters for the American Dental Association (ADA). Standard consumer satisfaction surveys, such as the Medical Outcomes Study Short Form (MOS SF-36) and the Group Health Association of America, Inc. (GHAA) consumer satisfaction survey that were collected were also reviewed.

QCMC staff reviewed a copy of the draft Medicaid HEDIS document from the National Center for Quality Assurance (NCQA) and reviewed by the documents for measures pertinent to CSHCN. Measures were reviewed from several MCHB-funded projects, including: the Family Health Outcomes Project in California; the CHILD Profile Care Coordination Data project of the Seattle-King County Department of Public Health; New England SERVE; and Bright Futures.

The *QCMC* project staff organized and facilitated meetings with Illinois parents and CSHCN advocacy group representatives in order to obtain consumer input on overall issues of quality of health care for CSHCN and their families, review and rank the *QCMC* measures, and recommend methodologies for collecting data from families with CSHCN.

A mail survey of 300 pediatricians providing services to CSHCN in Illinois was conducted by project staff. These physicians were selected based on their identified interest in CSHCN through a survey conducted by the Illinois Chapter of the American Academy of Pediatrics. One-hundred-eleven of these physicians reviewed and ranked the *QCMC* suggested measures and recommend methodologies for collecting the data.

QCMC staff has begun testing a subset of these suggested measures at the state CSHCN agency in Connecticut. The Connecticut program has contracted with the major tertiary care centers to provide care coordination and payment for services needed by CSHCN under capitated arrangements.

The *QCMC* staff wishes to thank the following people for their comments and suggestions regarding this *Guide*: Michele A. Kelley, Sc.D, M.S.W., M.A., Associate Professor of Maternal and Child Health, Community Health Sciences, The University of Illinois at Chicago; Margaret McManus, M.H.S., McManus Health Policy, Inc.; Susan G. Epstein, M.S.W., Co-Director; New England SERVE; and Ann B. Taylor, Ed.D., Co-Director, New England SERVE.

WHAT'S IN THIS GUIDE?

This *Guide* is an effort to provide a set of measures that can be used to monitor CSHCN in managed care plans or to monitor services funded by state CSHCN programs. There are two sets of measures included in this *Guide*: 1.) a set of measures developed by the MCHB-funded *Quality Community Managed Care (QCMC)* project described above; and, 2.) a subset of **Medicaid HEDIS** measures, developed by the National Committee for Quality Assurance, deemed relevant to children and youth.

While time and money can be spent developing measures specific to the CSHCN population, the fact is that health plans and purchasers are already using **HEDIS 2.5** (the **Health Plan Employer Data and Information Set**) and **Medicaid HEDIS (December 1995)** measures as a starting point for their quality assurance measures. **HEDIS 2.5** and **Medicaid HEDIS** will be superseded by **HEDIS 3.0** in 1996. Given this situation, this *Guide* uses the framework suggested by **HEDIS**, which is organized by topical area: membership, utilization, quality, access, health plan management, clinical management systems, and finance, as the base for developing CSHCN-specific quality assurance measures. Measures pertinent to children or measures that were stratified by ages that included children were selected from the **Medicaid HEDIS** document to provide a starting point for adapting measures for your specific CSHCN population.

Each measure pertinent to the CSHCN population is described, along with the necessary data items, i.e., the numerators (N) and the denominators (D), and suggested sources, (e.g., hospital discharge data, plan encounter data, etc.) for collecting the data items which comprise each measure in this *Guide*. Page numbers are also provided where more information can be found on the measure in the **Medicaid HEDIS** document.

Since the process of implementing managed care and measuring varied monitoring plans will be a long-term, ongoing process; different scenarios may emerge in various states. The following scenarios suggest ways in which your program might best use the information provided in this *Guide*, depending upon the progress and direction of the transition to managed care in your state.

Scenario A: Using Medicaid HEDIS Measures Only

Your state Medicaid agency plans to implement some or all of the HEDIS measures for collecting data and measuring and monitoring the performance of the providers for your CSHCN population. Study the numerator, denominator, and suggested sources for collecting each HEDIS measure in this *Guide* to determine how to modify and clarify the measures to best serve your pediatric and CSHCN population.

Scenario B: Using Medicaid HEDIS Measures with Modifications

Your state Medicaid agency plans to implement the HEDIS measures for now, but is open to additional suggested measures. Use the *QCMC Measures* as additional measures, or as a jumping off point for creating additional measures relevant to the population your agency is serving.

Scenario C: No Measures Selected

Your state Medicaid agency has developed a quality assurance plan but has not decided on which measures would be used. Use all of the measures in this *Guide* as a foundation for crafting your quality assurance measures.

Scenario D: Using Claims Data as Source for Quality Assurance Measures

Your state Medicaid agency has decided to develop quality assurance measures based on existing Medicaid claims data. Prior to managed care, most providers focused on collecting information associated with payment of claims. Measures that can be generated from this source will provide you with at least some collectible data in the first year or two of the transition, and will allow providers some time to expand their staffing and databases to collect additional data in subsequent years.

Another option under this scenario is to collect data on specific conditions. For example, pediatric-specific measures related to asthma and low birth weight already exist. Collect the data on these conditions while working to add other pediatric specific issues to your dataset.

Scenario E: State CSHCN Program Develops a Quality Assurance System

Your state Medicaid agency seeks input from the state CSHCN program to develop specific measures CSHCN. Under this scenario, use some or all of the measures in this *Guide*.

In addition to understanding the progress and direction of your state in implementing managed care for the CSHCN population, it is important for your program staff to:

- initiate an ongoing, non-adversarial process involving all the stakeholders, e.g., states Medicaid agencies, providers, and parents.
- decide what your Title V program has to offer to providers: practice guidelines, data expertise, and ability to identify special needs children, and so forth.

Under managed care, the role the state programs have changed; come to the table with something to offer. Work with your staff to help them understand the impact of managed care upon their roles: most health professionals' experience is grounded in social work and/or clinical fields. It is now imperative that they learn more data analysis and computer skills, as well as administrative rather than advocacy skills.

ISSUES RELATED TO SELECTION OF MEASURES

There are several issues to think about when selecting measures for your dataset:

- Be specific about the data items you want collected.
- Understand how the measures are constructed, i.e., what data items comprise the numerator and the denominator.

- Think about sources for collecting the data. Decide which items can be collected now and which items will require additional coordination among providers and your program, and/or additional time for systems development.

In addition, it is important to think about broader topics as they relate to the CSHCN population:

◆ Age

Think about the age group breakdowns of the data your providers may be collecting currently. If the current parameters are broad, simply ask your provider to break out the age parameters based on the ages of the children in your program.

◆ Geography

Try to get your Medicaid data on at least a county level. If this is not possible, provide a clear definition of a catchment area. If the bulk of your population served is in one county, request that the provider indicate the name of the county.

◆ Integrated Measures

Develop measures to be integrated. This means developing related measures on a single issue that span utilization, quality, access, etc. Comparing across measures can provide valuable information on system problems and successes. For example, **Medicaid HEDIS** has the following set of integrated mental health measures:

- Proportion of children who received any mental health service who received inpatient mental health service; Number and rates of discharges per 1,000 members, average length of stay for children by age group and by gender;
- Percent of plan members receiving any inpatient, day/night, or ambulatory mental health services;
- Number of members hospitalized for specified mental health disorders;
- Percentage admitted for specified mental health disorders who are readmitted within 90 or 365 days, by age and gender;
- Chemical dependency inpatient discharges, rate per 1,000 members, average length of stay for children by age and gender;
- Number of members hospitalized for chemical dependency by age and gender;
- Percent of members readmitted for chemical dependency within 90 or 365 days by age and gender;
- The percent of Medicaid enrolled adolescents aged 12 to 21 during the reporting year who received substance counseling during the reporting year

- The percentage of Medicaid members, aged 11-64 years, hospitalized for treatment of specified mental health disorders who were seen on an ambulatory basis within 30 days of hospital discharge;
- The proportion of mental health care providers who serve children and are accepting new Medicaid beneficiaries; and
- The proportion of mental health care providers reporting they have adequate knowledge to care for CSHCN.

◆ National Standards

Develop or select measures that you can compare to a standard. Standard or comparison measures may come from group consensus (e.g., Healthy People 2000) or state and national surveys (e.g., National Health Interview Survey, National Disability Survey, etc.)

◆ Set Up Criteria

An MCHB-funded project, Family Health Outcomes Project (FHOP), at the University of California at San Francisco, used the following criteria to assess the relative merits of proposed performance measures by the Medicaid HEDIS Committee. FHOP criteria included that the measures:

- be relevant and informative to consumers, purchasers, and providers of care;
- derive from documented authoritative standards;
- be feasible for most health plans to provide in the specified manner (routinely obtainable from the health plan administrative data set or medical records);
- measure an aspect of managed care plans' structure, processes, and outcomes that is under the significant influence of the health plan;
- continue to evolve through incorporation of new performance measures and revision or deletion of the old measures as new information is developed and defined;
- protect confidentiality; and
- be comparable with population based Healthy People 2000 objectives, (where possible).

ANALYTICAL ISSUES RELATED TO USING MEASURES

Summary Measures

The majority of measures used in quality assurance monitoring are summary measures. A summary measure consists of data from individuals that has been aggregated or summed. Summary measures are fixed measures; in other words, no more information can be obtained from a summary measure once it has been summed.

For example, the HEDIS measure "rates of discharge from all non-acute care settings (for children ages <1, 1-19)" includes information for inpatient care that is hospice, nursing home, rehabilitation facilities, SNF, transitional care or respite, regardless of type of facility. Once the data in all of these categories are summed, information of interest to CSHCN, such as the use of respite care or rehabilitation cannot be viewed separately. In this case, it is recommended that the measures be stratified by type of nonacute care.

Because the numbers for any one age group in these categories will be small, you may choose to report the measure for all ages.

Compare Measures to a Standard

In order to be meaningful—and of use in the development of objectives and surveillance strategies—a standard measure or identified expected level must be available for comparison. Without a standard for comparison it will be impossible to compare plans serving different populations, compare plan populations to the general population, or make any kind of statistical comparisons.

There are numerous items that can be used from national surveys that are relevant to CSHCN. For example, the National Health Interview Survey has items such as parental view of child's health (poor, fair, good, excellent); annual number of office visits by type of condition; and level of activity limitation by condition.

As this data is collected in a manner to be representative of the general population, standard or comparison measures can be developed by aggregating all available plan or program data for the same measures. For example, sum all data for a measure across all plans/contracts and recompute the rate/percent. This measure represents a mean for the plan and can be compared to the rate/percent for the general population. In addition, you may examine whether the level of the measure is above or below the mean for all persons served across plans or contracts.

Stratifying Measures to Allow Meaningful Reporting of Populations Risk

There are numerous population characteristics that have direct affects on the level of a measure. Stratifying (or reporting a measure by the level or status of a characteristic such as age group, gender, or race, etc.) measures on these characteristics allows us to examine the level of a measure on populations particularly at risk for poor health outcomes. Important characteristics include age, gender, size of the family, number of parents, type of condition, and so forth.

For each measure, identify which groups are most at risk. For example, gender is a strong risk factor for suicide in adolescence. To allow appropriate interventions to be developed in response to this measure, it would be important to have the measure reported by gender. Income is a strong risk factor for the presence of and the extent of a disability. Even if data are reported from Medicaid supported plans; it may be helpful to stratify further on income.

Steps in Thinking About the Analysis/Reporting of a Measure

Describe the general measure (type of proportion, numerator, denominator).

Describe how the measure will be used once you obtain it. Include any related measures in the description.

Describe how the measure will be stratified (e.g., age, condition, income, etc.).

Describe the sources for the measure (e.g., encounter data, survey of clients, site visits, written assurances, and so forth).

Describe any comparison or standard measures that exist.

◆ Does the measure resemble any existing classical public health measure?

Strategies for Quality Assurance Data Collection and Review

There are many strategies that may be used to collect and review data for quality assurance and CSHCN. The following is a review of some of these strategies:

- ◆ Develop a survey (preferably a key informant type). The potential survey participants include:
 - plan providers/staff, and
 - consumers of plans.
- ◆ Develop items to review through site visits to providers/plans
- ◆ Use information you obtained from your needs assessment to develop a resource inventory of critical services and examine the plan's usage of these services:
 - pediatric centers;
 - pediatric subspecialists;
 - community-based specialty clinics;
 - multidisciplinary centers;
 - comprehensive care coordination services; and
 - family support programs.
- ◆ Identify a few sentinel measures and limit the data collection process to those measures.
- ◆ Modify existing HEDIS measures, especially those that require narrative. For example, narrative regarding studies on the quality of care could include the description of a project targeted to CSHCN; the case management narrative could include a detailed case study of a child with a complex illness; and the member orientation/education could include information specific on how CSHCN are to access services.

- ◆ Identify a few easily identifiable conditions which represent domains of disability (e.g., need for medication, need for assistive devices, etc.) and request that reports include these conditions as strata in their summary measures.
- ◆ Review groups of measures within each category. For example:
 - Quality
 - Examine immunizations among a group of children with chronic conditions
 - Examine parents' view of their child's health status
 - Examine parents' view of improvement in their child's health status
 - Access
 - Identify the number of visits to primary care providers for selected CSHCN
 - Review type of centers used for cardiac surgery, hemophilia treatment, etc.
 - Review referrals to specialty care providers and follow-up
 - Look at the number of CSHCN served by providers participating in the plan/program
 - Look at the number of providers that serve CSHCN and accept Medicaid payment
 - Are parents reporting that care delivered by the plan is coordinated?
 - Health Plan Management
 - Obtain information on providers' perceived adequacy (or need for training to care for CSHCN)
 - Expand provider credentialing to include nurses, therapists, and other professionals caring for CSHCN
 - Clinical Management Systems
 - Include a quality improvement study or studies specific to children with chronic conditions when providing the narrative on Quality of Care studies
 - Regarding case management: identify specific conditions that have clinical protocols and standard educational programs and require plans to specify the case management approaches to be used
 - Review the pre-authorization process for all services required for the treatment of chronic conditions

- Are parents reporting they have received adequate information about their child's condition and care?
 - What proportion of parents have signed/approved their child's care plan?
 - Review the number and nature of complaints/grievances filed for CSHCN
 - Proportion of CSHCN over age 14 with a plan for transition to adult services
 - Identify professionals' knowledge and use of programs critical for many CSHCN (e.g. early intervention and family support services, etc.)
 - Describe the approach to new member orientation for those whose children require the ongoing use of specialty services
- ◆ Develop a comprehensive QA system in your state CSHCN program:
- use the data to demonstrate effectiveness of measures, and
 - use the process to gain experience in collection and analysis of measures.
- ◆ Identify measures across programs which can be integrated to elicit information on a specific topic. For example, regarding grievance procedures and policy the following could be reported:
- Number of parents who have knowledge of the grievance procedure;
 - Evidence of a written grievance procedure policy;
 - Chart review on clients with grievances;
 - Presence of grievance procedures at the site;
 - Proportion of parents who have knowledge of program's grievance procedures and due process; and
 - Proportion of parents who filed formal complaints/grievances in the last 12 months with the program.

**QUALITY ASSURANCE MEASURES
for
CHILDREN with SPECIAL HEALTH CARE NEEDS,
includes
PERTINENT MEASURES FROM MEDICAID HEDIS**

The measures that follow are grouped by major topic area:

membership, pages 17-18	health plan management, pages 39-40
utilization, pages 19-27	clinical management systems, pages 41-45
quality, pages 28-34	finance, page 47
access, pages 35-38	

The *QCMC* project measures are listed first, followed by the **HEDIS** measures.

- ◆ Numerators are indicated by an (N); denominators are indicated by a (D).
- ◆ Suggested sources for collecting the data items which comprise each indicator in this *Guide* are keyed as follows:

A - Assurances (written documentation)	P - Plan Encounter Data
B - Billing information	PAI - Plan Administration Information
C - Census	R - Record Review
E - Health Plan Enrollment Information	SF - Survey of Families
H - Hospital Discharge Data	SP - Survey of Providers