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Issue Brief



New Opportunities for Integrating and Improving Health Care for Women, Children, and Their Families

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ABSTRACT: The Patient Protection and Affordable Care Act gives states new tools and funding to integrate public and private delivery of health care services. Many states are already integrating services for low-income women and children to improve outcomes and reduce costs. For example, many state Medicaid agencies and the Children's Health Insurance Program, public health agencies, provider groups, private insurers, children's hospitals, and family organizations are partnering to share resources including technical assistance, coordinated care, and quality improvement efforts. This issue brief highlights the efforts of Colorado, Florida, Ohio, and Vermont to integrate health care services for low-income women and children, especially through state Title V maternal and child health programs.

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OVERVIEW

Until recently, most public and private health care insurance and delivery systems operated in parallel, with little or no coordination among providers or payers. As a result, families often had to navigate these complex systems unassisted, providers were often reluctant to refer patients for additional services and supports such as home visiting and care coordination from community-based agencies that they knew little about, and public and private systems risked duplication of effort.

That situation is beginning to change, as the Patient Protection and Affordable Care Act moves states into the driver's seat of health care reform and health care systems consider expanding their responsibilities to include population health and enhanced preventive care. The Affordable Care Act gives states tools and resources to integrate public and private health care systems to improve quality and efficiency and reduce costs. These opportunities include a renewed focus on creating patient-centered medical homes. More than 30 states have already begun to promote medical homes through Medicaid and the Children's

Health Insurance Program (CHIP).¹ States can avail themselves of these new opportunities by building on existing efforts to further integrate services for vulnerable populations, improve quality, and reduce costs.

National policies can help promote integration of services. For example, Early and Periodic Screening, Diagnosis, and Treatment—Medicaid’s program for individuals under the age of 21—has long required state Title V and Medicaid agencies to coordinate their efforts.

This issue brief highlights the efforts of state Title V maternal and child health programs and their partners in Colorado, Florida, Ohio, and Vermont to integrate public and private health care services for low-income women, children, and their families. The brief outlines the roles and strategies of state agencies, and shows how these programs have already begun to improve children’s health and reduce health care costs.

NEW OPPORTUNITIES FOR PUBLIC–PRIVATE PARTNERSHIPS

Evidence is growing that enhanced models of primary care, such as integrated hospital and community-based systems and patient-centered medical homes, improve maternal and child health and well-being.² Investments in better models of primary care can also lower costs.³

Fortunately, the Affordable Care Act provides new tools and funding to help states build on existing efforts to integrate service delivery and build new models of primary care. These opportunities include:

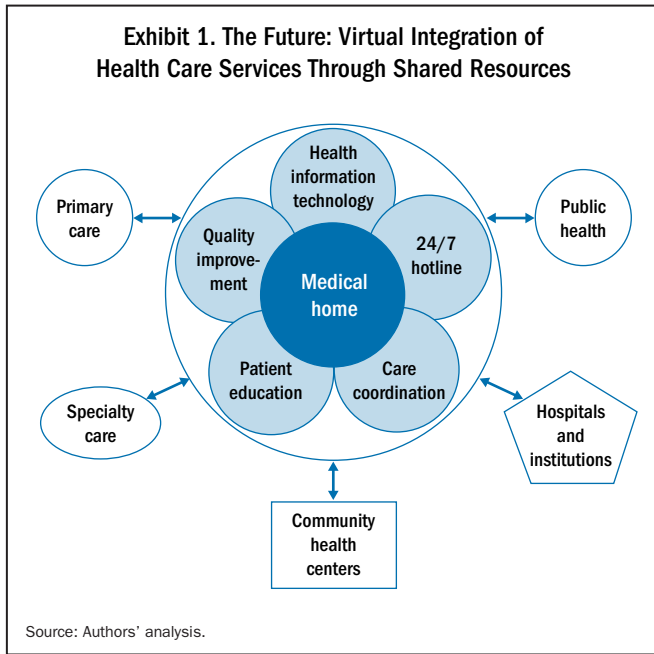
- the Medicaid Health Home State Plan Option (Section 2703 of the Act), which offers states enhanced funding to establish health homes for persons with chronic conditions;
- Community Transformation Grants, which provide new investments in community-based prevention programs;⁴
- Community-Based Collaborative Care Networks, which authorize funding to hospitals, community health centers, and other providers to offer coordinated care for vulnerable patients;

- requirements that states establish health insurance exchanges;
- funding for investments in disease prevention and public health;
- expansion of community health centers; and
- quality improvements advanced by the Center for Medicare and Medicaid Innovation of the Centers for Medicare and Medicaid Services (CMS).

Most if not all of these opportunities require primary care providers to assume additional responsibilities and change the way they practice. For example, these provisions require providers to manage chronic illnesses and identify and treat behavioral disorders.⁵ Health care reform also assumes that primary care providers—especially those that serve as patient-centered medical homes—will adopt electronic health records, and use them to report on and improve the quality of care.⁶ These new requirements and expectations are challenging providers’ capacities and resources.

For states and providers to succeed, they must forge partnerships that serve the needs of both public and private participants. These partnerships will need to leverage scarce resources, provide technical and material support to primary care practices, link primary and specialty care, minimize duplication of effort, and identify new policy and programmatic approaches to systems change (Exhibit 1).

One promising strategy for such public–private partnerships is the creation and use of mechanisms for sharing resources, such as care coordinators, technical assistance to provider groups, and joint efforts to collect, analyze, and report data for quality improvement (Exhibit 2). These collaborative efforts can improve the quality of care, help providers maximize their time with patients, reduce costs, bolster staff training and provider awareness of community-based resources, and strengthen links between primary care practices and community-based services.⁷



HOW STATE MCH PROGRAMS CAN PROMOTE SERVICE INTEGRATION

All states and U.S. territories receive funds from the Title V Maternal and Child Health (MCH) Services Block Grant to build a comprehensive system of programs, services, and supports for women and children. This federal program provides critical funds for improving infant and child health, reducing infant and maternal mortality rates, and providing prenatal care to low-income women.

States have considerable flexibility in using Title V funds to support the provision of health system

supports, such as care coordination and translation services, and, varying by state, payment for direct services. At least 30 percent of Title V funds must address population needs for preventive and primary care, and another 30 percent must serve children with special health care needs. Experience with these programs has yielded considerable expertise in the creation and operation of integrated services. State Title V MCH programs administer numerous public efforts that are natural access points for building and strengthening integrated service delivery systems. These include prenatal care programs, home visitation, Early Intervention for children with developmental delays (Part C of the Individuals with Disabilities Education Act), Special Supplemental Food and Nutrition Program for Women, Infants, and Children (WIC) programs, specialty clinics for children with special health care needs, and state-wide toll-free hotlines to facilitate access to care.

While no state entity is singly responsible for child health, as neutral conveners state Title V MCH programs can bring together public and private stakeholders to reach consensus on challenges in redesigning health care delivery to meet the unique needs of women and children, such as setting standards for care and devising new approaches to evaluating and paying for care.⁸

Requirements for state Title V programs and Medicaid agencies to coordinate Early and Periodic

Exhibit 2. State Public Health Resources That Support Primary Care Practices

| Core public health functions* | Resources for service delivery | Resources for clinical management | Resources for clinical care |
|-------------------------------|--|--|--|
| Assessment | <ul style="list-style-type: none"> Collecting, monitoring, and reporting data | <ul style="list-style-type: none"> Measuring quality | <ul style="list-style-type: none"> Improving quality |
| Policy development | <ul style="list-style-type: none"> Convening state and local partners to identify priority needs and goals Developing partnerships | <ul style="list-style-type: none"> Providing technical assistance and training to providers | <ul style="list-style-type: none"> Providing technical assistance and training to providers |
| Assurance | <ul style="list-style-type: none"> Engaging families Setting standards | <ul style="list-style-type: none"> Coordinating care Promoting electronic health records | Providing for patients: <ul style="list-style-type: none"> Home visitations Immunizations Education, such as on nutrition Toll-free hotlines Translation services Transportation |

*The landmark Institute of Medicine 1988 consensus report *The Future of Public Health* identified assessment, policy development, and assurance as essential to an efficient and effective public health system at national, state, and local levels. See <http://www.iom.edu/Reports/1988/The-Future-of-Public-Health.aspx>. Source: M. Abrams, E. Schor, and S. Schoenbaum, "How Physician Practices Could Share Personnel and Resources to Support Medical Homes," *Health Affairs*, June 2010 29(6):1194-99.

Screening, Diagnosis, and Treatment services—Medicaid’s program for individuals under the age of 21—provide an important starting point for such collaboration. Under the Title V block grant, states must:

- establish coordination agreements between state Title V and Medicaid programs;
- provide a toll-free number for families seeking Title V or Medicaid providers;
- provide outreach to and facilitate enrollment of Medicaid-eligible children and pregnant women;
- provide services for children with special health care needs not covered by Medicaid; and
- share responsibility for collecting data on the health of these participants.

Colorado, Florida, Ohio, and Vermont show how states can use these and other opportunities to integrate health care services for women, children, and their families. Their approaches include:

1. Engaging state and local stakeholders, such as Medicaid and CHIP agencies, providers, insurers, and families, in choosing strategic priorities and building statewide initiatives for transforming the health care delivery system for women and children, including children with special health care needs.
2. Building comprehensive service delivery systems for children with special health care needs.
3. Providing or paying for supports for providers that serve women and children, such as care coordination and home visiting.
4. Using public health, Medicaid, and other data sources, and the expertise of these and other groups, to improve the quality of health care for women and children at the state, local, and practice levels.

These states have begun what is likely to be a long-term effort to foster integration within their child health programs (see [Appendix](#)).

ENGAGING KEY STAKEHOLDERS, INCLUDING FAMILIES

Initiatives to integrate health care delivery systems benefit significantly from partnerships between the public and private sectors, since no single state agency or organization is solely responsible for the range of programs, services, and supports that children and their families need and use. Every stakeholder has unique resources and expertise to provide and scarce resources need to be maximized.

Among the many stakeholders, the participation of consumers is key to successful delivery system redesign. State Title V MCH programs have typically worked closely with child and family advocacy groups to promote family-centered care. These programs are therefore positioned to involve these stakeholders in efforts to redesign the health care delivery system. Colorado provides a model for such efforts.

The Colorado Department of Public Health and Environment, Division of Family Health Services (the state’s Title V MCH program) began the **Colorado Medical Home Initiative (CMHI)** in 2001 in partnership with the Department of Health Care Policy and Financing (the state’s Medicaid agency), provider groups like the Colorado chapter of the American Academy of Pediatrics, and Family Voices Colorado, which promotes access to high-quality health care for children with special health care needs. The initiative aims to “develop a sustainable system that delivers quality health care for all children” by creating medical homes.⁹ Initially targeted to children with special health care needs, the initiative has been expanded to focus on all Medicaid-enrolled children in the state. These initial efforts to integrate services through a medical home were bolstered in 2007 with the passage of Colorado SB 07-130, which defined a medical home and the roles of key state agencies in integrating health care systems and sharing resources to provide care.

Since then, the Division of Family Health Services, the Department of Health Care Policy, and other groups have been taking several steps to implement that approach through the CMHI. These include:

- Developing comprehensive standards to guide the development of medical homes. These standards apply to medical, dental, and mental health providers serving children eligible for Medicaid or CHIP.
- Relying on Family Voices Colorado to certify local medical, dental, and mental health care practices to become medical homes, and using “medical home navigators” to help practices become certified. Certified practices receive a pay-for-performance rate for providing enhanced care.
- Expanding developmental screening of children by participating primary care practices. To do so, the program partnered with the Assuring Better Child Health and Development project, a national initiative financed by The Commonwealth Fund and administered by the National Academy for State Health Policy, an independent organization of state health policymakers.
- Provided a toll-free help line—funded by the state Medicaid agency and foundations—to help primary care providers refer families to community-based services for follow-up care.
- Implemented a process to give families of children with certain medical conditions, such as Down syndrome, a list of community-based resources when they check out of primary care practices. These referrals are triggered by the ICD-9 codes¹⁰ for the medical conditions.

Early results are promising. For example, preventive screenings for children in Colorado enrolled in Medicaid increased from 500 to 20,000 screenings each quarter over a three-year period.

BUILDING SYSTEMS TO SERVE CHILDREN WITH SPECIAL NEEDS

State Medicaid and CHIP agencies typically lead state efforts to finance and assess the performance of health care service delivery systems and pay for services for enrollees, including low-income women and children and their families. One exception is the care of children with special health care needs. As noted, federal law requires state Title V programs to devote at least 30 percent of Title V block grant funds to these children.¹¹

State Title V programs also are charged with ensuring that such children have access to comprehensive, community-based, culturally competent, and family-centered health care—a medical home. As a result, many state Title V programs work closely with their Medicaid and CHIP counterparts, providers, families, insurers, and other groups to build and integrate public–private delivery systems for children with special needs and their families.

Florida’s **Children’s Medical Services (CMS) Network** is a unique public–private system that has evolved over three decades to meet the needs of children with special health care needs enrolled in public insurance programs. The CMS Network includes both primary and specialty care providers experienced in serving this population, as well as all providers and services under Florida’s state Medicaid plan.

Established in 1996, the network serves as a managed care plan for children with special health care needs who are enrolled in Medicaid and CHIP.¹² Families of Medicaid- and CHIP-eligible children who meet the clinical screening criteria for the CMS Network can choose it as their plan. The network’s comprehensive benefits include medical, mental health, and dental care, palliative care for children, and parental supports such as respite care. Twenty offices throughout the state serve more than 80,000 children.

The network’s roots date from the 1980s, when advocacy from the Florida chapter of the American Academy of Pediatrics and leadership from the governor’s office and state legislature led to a state budget appropriation to the Florida’s Title V MCH program to develop regional Centers of Excellence for children

with special health care needs. Federal Medicaid expansions in 1989 then spurred a further partnership between the state Title V program, Medicaid, provider groups, insurers, and families to develop a comprehensive benefits package and continuum of services for children with special health care needs enrolled in Medicaid.

The role of the state Title V program in the network has evolved with changes in state and federal programs such as CHIP. For example, using a demonstration grant under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the state Title V program is promoting medical homes for all children eligible for Medicaid or CHIP, with an emphasis on those with special health care needs.

The state Title V program identifies children with special health care needs, works to enroll and retain them in care, and coordinates that care. The program also certifies providers, contracts directly with them, manages premiums, and processes claims. The program further manages health care quality through peer review, utilization management, clinical reviews, and determinations of medical necessity for certain services, procedures, and pharmaceuticals. The state Medicaid agency, meanwhile, establishes state Medicaid policy, pays providers, and advances quality assurance and improvement efforts.¹³

Because of these efforts, the CMS Network is a high-performing plan in the state's two Medicaid waiver sites. The plan recently exceeded Healthcare Effectiveness Data and Information Set (HEDIS) measures for several key indicators of child health, including: immunizations (75.7% for CMSN vs. 75.4% benchmark), well-child visits (79.2% for CMSN vs. 67.5% benchmark), follow-up on asthma medications (89.0% for CMSN vs. 88.7% benchmark), and follow-up care for children prescribed medication for attention deficit and hyperactivity disorder (57.4% for CMSN vs. 35.5% benchmark). The network also saved \$31.45 million in health care costs in less than three years (2006–2009).

PROVIDING OR PAYING FOR CARE COORDINATION

Coordination of care plays an important role in helping women, children, and families—particularly those who are low-income or have special health care needs—obtain services and support. Coordination of care is particularly essential for children with a chronic physical, developmental, behavioral, or emotional condition, or who have a higher risk of developing such a condition.¹⁴

Evidence suggests that primary care providers value care coordination. However, most practices lack the resources to support a staff member to provide that service.¹⁵ State Title V programs typically pay for efforts to coordinate care—or actually provide such coordination—for pregnant women and children with special health care needs. State Medicaid agencies, meanwhile, play a key role in funding care coordination for Medicaid enrollees.¹⁶

States could enhance integrated service delivery by coordinating care, or funding such coordination, and providing other support for primary care practices. Florida's CMS Network again provides a model. The network pays for pediatric primary care practices within six regions of the state, as part of efforts to develop medical homes for children with special health care needs. Under a federal CHIPRA demonstration grant, the network is expanding these efforts to all children eligible for Medicaid or CHIP, with an emphasis on children with special health care needs. These efforts stem from a partnership between the national office of the American Academy of Pediatrics, its Florida chapter, and the state Medicaid and Title V programs.

DEVELOPING STANDARDS AND PROMOTING QUALITY

Transforming health care delivery systems to ensure high-quality health care is a primary objective of state and national health care reform. Both the Affordable Care Act and CHIPRA include mandates for improving quality of care, with the latter focusing specifically on improving children's health care through quality

initiatives that affect both CHIP and Medicaid. The act requires HHS to publish an initial set of quality measures for children, provide technical assistance to states to improve pediatric care, and create a new format for children's electronic health records. The act also requires HHS to fund demonstration projects on quality improvement and health information technology in 10 states, and to report to Congress on pediatric health and measures of that health.¹⁷

In addition to these federal mandates, shortfalls in state budgets are providing further stimulus to improve health outcomes while reducing health care costs. Many of these efforts—including those in Ohio and Vermont—show how states can work with the private sector to improve health care quality.

Best Evidence for Advancing Child Health in Ohio Now (BEACON) is a statewide child health quality improvement collaborative in Ohio, funded by the state, federal Medicaid matching funds, and other grants, with a special emphasis on Medicaid-eligible children.

Some 21 members of the BEACON Council represent children's hospitals, businesses, insurers, child advocacy groups, universities, and key state agencies, such as Medicaid, Title V, and mental health.¹⁸ The BEACON agenda is closely tied to the state Medicaid agency's quality improvement strategy. Its current portfolio of quality improvement efforts includes promoting innovation and cost-effectiveness through initiatives such as the Ohio Perinatal Quality Collaborative and through efforts to expand developmental screening for children.

These efforts have produced impressive results. For example, children's hospitals and pediatric providers have reduced surgical infections for certain procedures by 50 percent, and adverse drug events by 35 percent. These efforts saved 3,576 children from unnecessary harm, and more than \$3 million in costs.¹⁹ Through the Ohio Perinatal Quality Collaborative, 24 hospitals representing nearly half of the state's births reduced late preterm births (babies born at a gestational age of 34 to 36 weeks and six days) by 20 percent over

a 20-month period. In so doing, the state estimates that it avoided nearly \$10 million in health care costs.

The **Vermont Blueprint for Health** is a statewide public-private health care reform initiative that was mandated to statewide expansion in May 2010. The Blueprint Integrated Health Services recognizes Advanced Primary Care Practices (APCPs) as patient-centered medical homes, and requires major insurers to support Community Health Teams (CHTs) through payment reforms. CHTs are locally based groups of multidisciplinary practitioners that support patients who receive care in the associated APCP. The teams are designed at the local level and informed by community-wide assessments of local resources and gaps to help patients with and without chronic conditions adhere to preventive health guidelines.²⁰

The statewide expansion now includes 12 primary care pediatric practices from across the state with certification as medical homes from the National Committee on Quality Assurance (NCQA). An additional 20 pediatric practices in the state are assessing their readiness for NCQA certification.

As part of this work, Blueprint Integrated Health Services is focusing on four measures of high-quality pediatric care: preventive services, as well as treatment for attention deficit hyperactivity disorder, asthma, and childhood obesity. The state Title V MCH program is working with the state chapters of the American Academy of Pediatrics and the American Academy of Family Physicians, and with the Vermont Child Health Improvement Program, to ensure that APCPs offer preventive services, as outlined in the state's Bright Futures guidelines from the American Academy of Pediatrics.

LESSONS FOR OTHER STATES

These four states—Colorado, Florida, Ohio, and Vermont—demonstrate the range of strategies that state Title V MCH programs and other stakeholders can use to strengthen efforts to integrate public and private health care systems. These strategies include:

- Convening statewide task forces composed of state Title V MCH, Medicaid, and CHIP programs, children's hospitals, provider groups, insurers, researchers, and family organizations, to integrate service delivery systems and develop new models for primary care.
- Using new and existing funding opportunities to integrate public-private service delivery systems and promote quality. These opportunities include elements of the Affordable Care Act, such as the Medicaid Health Home State Plan Option (Section 2703), and existing funding strategies, such as Medicaid administrative funding and enhanced provider reimbursement.
- Using the flexibility of the Title V MCH Services Block Grant to share resources, such as through care coordination, statewide toll-free hotlines, and technical assistance to providers.
- Engaging families served by state Title V MCH programs in developing integrated health care service systems at state and local levels.
- Using public health and Medicaid data to improve the quality of health care services.

CONCLUSION

Many state health care insurance and public health programs have experience with collaborative or integrated delivery of health care services, and are well-positioned to guide new initiatives. The Affordable Care Act gives states new opportunities and funding to further integrate health care delivery systems, share public and private resources, and promote new models of primary care.

A variety of public-private stakeholders is needed to ensure that the promise of the Affordable Care Act to increase coverage, improve quality, and reduce health care costs can be readily achieved. Collaborative efforts by state Title V MCH, Medicaid, and CHIP programs, providers, private insurers, families, and other stakeholders are essential to ensuring that revamped health care systems meet the needs of women, children, and their families, particularly those who are low-income and underserved.

NOTES

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Appendix. How Four Key States Integrate Health Care for Low-Income Children and Women

| State initiative | Selected state efforts to integrate services | Key partners | Role of state Title V MCH program | Selected innovations | Early impact |
|--|---|--|--|---|---|
| Colorado Medical Home Initiative (CMHI): Medical homes for Medicaid-eligible children | <ul style="list-style-type: none"> State-funded care coordinators Statewide hotline on community resources for providers and families Technical assistance to providers for enrolling families in Medicaid and CHIP and billing for services | State task force representing more than 40 stakeholders, including state Title V and Medicaid agencies, primary care providers, foundations, businesses, child advocates, and families | <ul style="list-style-type: none"> Convening state task force on CMHI Engaging families in CMHI Setting care standards for practices that qualify as medical homes | <ul style="list-style-type: none"> Pay for performance for certified medical home providers Family involvement in certifying medical homes The use of ICD-9 codes to trigger family follow-up and referral to outside resources | <ul style="list-style-type: none"> Rise in preventive screenings for Medicaid children from 500 to 20,000 on average per quarter Greater family satisfaction with health care services from certified medical home providers |
| Florida Children's Medical Services Network: For eligible children with special health care needs | <ul style="list-style-type: none"> Care coordination Data for quality improvement and assurance activities Technical assistance to primary care providers | State Title V and Medicaid agencies, state chapter of the American Academy of Pediatrics, families, and others | <ul style="list-style-type: none"> Recruiting, credentialing, and contracting with providers Coordinating care Engaging families through outreach, and determining eligibility Setting standards for health care services | <ul style="list-style-type: none"> Clinical service delivery system led by state Title V program Piloting of a specialty plan in two organized networks State-funded care coordination for all children served by the network | <ul style="list-style-type: none"> Rate of immunizations, well-child visits, and follow-up on asthma medications exceeded HEDIS child health measures \$31.45 million in cost savings in less than three years |
| Ohio Best Evidence for Advancing Child Health in Ohio Now (BEACON): Rapid quality-improvement initiatives targeted to Medicaid-eligible children and their families | <ul style="list-style-type: none"> Data for quality improvement in the state Medicaid program Data for quality improvement with providers Data for quality improvement impacting population health (e.g., vital statistics) | 21 stakeholders on the BEACON Council, including state Title V MCH and Medicaid programs, children's hospitals, providers, universities, insurers, and advocacy groups | <ul style="list-style-type: none"> Using public health data to improve quality Setting standards for preventive and clinical services for children Creating an infrastructure for collecting and sharing data across health care systems Investing in rapid-cycle quality improvement projects Convening experts to advance quality improvement | <ul style="list-style-type: none"> Active involvement of children's hospitals and medical providers in BEACON Medicaid cost savings, such as through reductions in late preterm births Identification of leading high-cost diagnoses and follow-up Standardized process for managing quality improvement across the state | <p>Public-private quality improvement efforts have resulted in:</p> <ul style="list-style-type: none"> a 50 percent drop in infections from some surgical procedures, and a 35 percent drop in adverse drug events, saving 3,576 children from unnecessary harm, and more than \$3 million in health care costs a 20 percent drop in late pre-term births over a 20-month period among 24 hospitals, avoiding \$10 million in health care costs 900 practitioners using developmental and autism screening tools at appropriate ages |

Appendix: How Four Key States Integrate Health Care for Low-Income Children and Women

| State initiative | Selected state efforts to integrate services | Key partners | Role of state Title V MCH program | Selected innovations | Early impact |
|---|---|---|---|--|--|
| Vermont Blueprint for Health: Statewide health care reform initiative | <ul style="list-style-type: none"> Care coordination Community Health Teams | Statewide partnership among state Title V, Medicaid, and human services agencies, provider groups, families, private insurers, universities, and others | <ul style="list-style-type: none"> Provision of public health prevention specialist to Community Health Teams Expansion of Blueprint for Health to the pediatric population Standard setting for pediatric care, including attention deficit and hyperactivity disorder, asthma, childhood obesity, and preventive services Quality assurance | <ul style="list-style-type: none"> Active involvement of all private insurers Community Health Teams Payment reforms to support preventive services Selected pediatric standards for quality improvement | <ul style="list-style-type: none"> Twelve pediatric practices across the state now have NCQA certification and an additional 20 pediatric practices are assessing their certification readiness Another 23 pediatric practices (among 35 statewide) await NCQA certification Identification of four child health measures: preventive services, attention deficit and hyperactivity disorder, asthma, and childhood obesity |

Source: Authors' analysis.

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