Children's Health Care Providers and Health Care Quality Measurement

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LAST YEAR, PRESIDENT Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA),[1] Public Law 111-3. A key component of the legislation, Title IV, mandated identification of an initial core set of children's health quality measures to be used by Medicaid and Children's Health Insurance Programs (CHIP) nationally. This is historic. It is the first piece of legislation that focuses specific attention on and crystallizes efforts to improve the quality of health of children nationally, and we hope that it is the beginning of a process that transforms the health of all of our nation's children.

The process to identify this core set of indicators resulted from an extraordinary collaboration between the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services. The Agency for Healthcare Research and Quality appointed a subcommittee of its National Advisory Council (SNAC) to identify the core set of measures to be presented to the Secretary of Health and Human Services. This subcommittee included noted experts in children's health and health research, leaders from the American Academy of Pediatrics and the American Board of Pediatrics, and representatives from Medicaid and CHIP programs. This initial core set of measures was identified by the SNAC from structure, outcome, and process quality measures that were already in use, and covers a broad range of child health care topics ranging from, for example, promotion of healthy birth, to *Chlamydia* screening of adolescents and follow-up for children using medicine for attention-deficit/hyperactivity disorder. The child health care quality measures selected by Secretary Sebelius from the SNAC-recommended set represent the first step in the process of assessing and improving the health of children in the United States.

Pediatricians and pediatric nurse practitioners, along with other provider organizations, have been at the forefront of promoting quality improvement and development of health care quality measures for children.[2–5] The CHIPRA-authorized work on this initial core set of children's health quality measures will help to define the quality of a greater range of activities in children's health care and, we hope, create incentives to implement the highest form of pediatric practice—the medical home.

Identification of this national set of pediatric health care quality indicators has major ramifications for child health care providers. These measures can enhance efforts of all providers to improve the quality of care in inpatient, outpatient, and ancillary settings. As provider organizations continue to engage health care professionals in child health care quality improvement and the integration of quality measures into their practices, it will be essential to familiarize providers of pediatric care with the balanced set of evidence-informed CHIPRA core measures. Some pediatricians and other child health providers are already using quality measures and improvement methodologies to improve their practices. A number of initiatives of the American Academy of Pediatrics[6] are now in the field to further assist practicing pediatricians.

We also believe that, over time, quality measurement will increasingly drive graduate education and continuing education and certification activities in children's health care, just as the new requirements of the American Board of Pediatrics tie maintenance of certification to documentation that practicing pediatricians are engaged in quality improvement activities.[6,7]

There are also opportunities (and challenges) for quality improvement in children's health care at the "systems" level. For example, quality measures are being incorporated into health care systems with specific tie-ins to payment. Such pay-for-performance (P4P) initiatives are often viewed as mechanisms that may improve health care quality and efficiency. Incorporation of valid and feasible quality measures into these initiatives has the potential to positively impact provider behavior. However, evidence that P4P models improve health outcomes is mixed.[8] In children's health care, evidence is currently lacking,[9] and there is a greater need for pediatric health care provider involvement in P4P program design and development of pediatric health outcome measures.[10]

In addition, Medicaid and CHIP programs currently use a variety of measures that do not allow valid comparisons of health outcomes between states, providers, or managed care organizations. Having a core set of standardized measures nationally will enhance that ability. This is information that will be crucial to the provider communities and consumers, as well as to state legislatures and Congress as they make decisions related to health care expenditures.

Implementation of the core measures also affords Medicaid and CHIP agencies an enhanced opportunity to improve communication and coordination between different agencies at the state and federal levels. But, more significantly, the measures provide a common language for Medicaid and CHIP programs and incentives to expand on existing collaborations, establish new partnerships, and foster innovations with child health care providers and the organizations representing them (American Academy of Pediatrics, American Academy of Family Physicians, National Association of Pediatric Nurse Practitioners, and others), because all have an interest in advancing the quality of children's health care. Demonstration projects, systems-based efforts, and ongoing working groups of stakeholders targeted toward quality improvement all become possible.

This is an important step, but it is only the first step. The core set of quality health measures currently is an imperfect list. Although the measures selected represent preventive health measures, acute and chronic diseases, ambulatory care, and in-hospital care, there still are diseases and other issues related to children's health for which valid and feasible measures could not be identified. This is particularly true for problems in adolescent health, such as drug and alcohol use, children with disabilities, and mental health concerns. Additionally, work remains to standardize the specifications of the core item set prior to any implementation. Still, the efforts of agency collaboration, the SNAC, and the coming implementation of the quality health indicators and initiatives oriented toward improvement and enhancement of the initial core set of measures offer a potential roadmap for establishment of an ongoing process of child health quality indicators development and review. Use of these indicators for quality improvement through the medical home will provide opportunities to improve care for children served in these programs and opportunities to use quality measures to spread this model.

We are at the beginning of this journey. Implementation of this core set of measures and improvements in children's health care quality will be slow and efforts sometimes halting. And the science of health care quality measurement as it relates to children must be enhanced. But with this landmark beginning, we have a focus and a purpose on a national scale.

REFERENCES

1. Children's Health Insurance Program Reauthorization Act of 2009. Public Law 111-3. Available at: https://www.cms.gov/HealthInsReformforConsume/Downloads/CHIPRA.pdf. Accessed October 7, 2010.
2. Steering Committee on Quality Improvement and Management and Committee on Practice and Ambulatory Medicine Pediatrics. Principles for the development and use of quality measures. *Pediatrics*. 2008;121:411–418.
3. National Association of Pediatric Nurse Practitioners. NAPNAP's Quality Activities. Available at: http://www.napnap.org/PNPResources/Practice/QualityActivities.aspx. Accessed August 7, 2010.
4. American Academy of Family Physicians. Quality Improvement (QI) Tools & Resources. Available at: http://www.aafp.org/online/en/home/practicemgt/quality/qitools.html. Accessed August 7, 2010.
5. Child Health Corporation of America. Improvement Services. Available at: http://www.chca.com/company_profile/pi/index.html. Accessed August 9, 2010.
6. American Academy of Pediatrics. Quality improvement (QI) at the American Academy of Pediatrics. Available at: http://www.aap.org/qualityimprovement/. Accessed March 22, 2010.
7. Miles P. Health information systems and physician quality: role of the American Board of Pediatrics Maintenance of Certification in improving children's health care. *Pediatrics*. 2009;123:S108–S110.
8. Glickman SW, Peterson ED. Innovative health reform models: pay-for-performance initiatives. *Am J Manag Care*. 2009;15(suppl 10):S300–S305.
9. Chien AT, Conti RM, Pollack HA. A pediatric-focused review of the performance incentive literature. *Curr Opin Pediatr*. 2007;19:719–725.
10. Chien AT, Colman MW, Ross LF. Qualitative insights into how pediatric pay-for-performance programs are being designed. *Acad Pediatr*. 2009;9:185–191.