CAHMI
The Child & Adolescent Health
Measurement Initiative

Maximizing quality measurement and improvement Of frameworks and leveraging existing data and methods

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Tri-State Children's Health Improvement Consortium Presentation

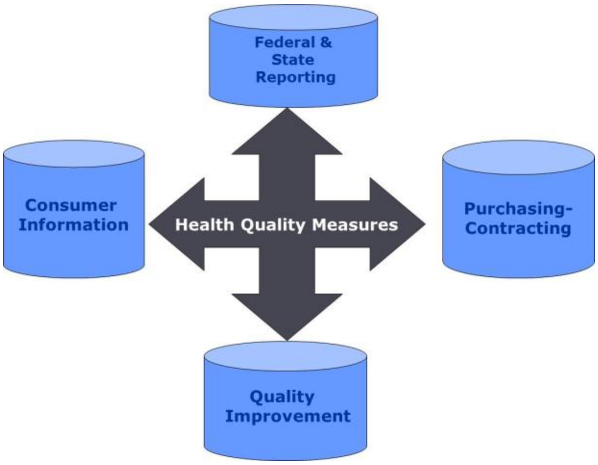
September 14, 2011

Overview

- **Using a Framework for Measurement** -- *Why we need one and what components must be addressed.*
  - What does the CHIPRA Legislation suggest about a Framework?
- **The National Surveys** -- *Why Wait? Using available data to look at children's health care quality.*
  - What National Survey data are available to address the CHIPRA Core Measure domains.
- **A Closer Look at the value of National Survey Data for *State-Level* Quality Improvement** –
  - How to think about using the data to support state-level QI?

Why a Framework for Measurement?

Meeting the Needs of Multiple Audiences



Why a Framework for Measurement?

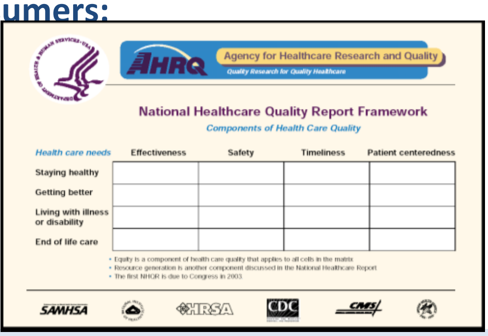
A roadmap to ensure measures are strategically selected to provide comprehensive coverage of the dimensions of children's health care quality in the most actionable and efficient manner possible!

- CMS Core Measures
- State-Specific Measures
- Meaningful Use Measures
- EPSDT Reporting
- CHIP Annual Reports
- Medicaid Reporting
- Title V Needs Assessment
- MCO Performance Measures
- EQRO Reporting

Building on Earlier Work

A look back at the Consumer Information Framework

- Initially developed by FACCT for CMS (then HCFA) – June 1997 (CAHMI)
- Adopted by IOM, AHRQ, NCQA, FEHB
- Tested with 700+ consumers:
  - Medicare
  - Commercial
  - Chronic disease
  - Parents of sick children
  - Medicaid



AHRQ Agency for Healthcare Research and Quality

Quality Research for Quality Healthcare

National Healthcare Quality Report Framework

Components of Health Care Quality

Health care needs	Effectiveness	Safety	Timeliness	Patient centeredness
Staying healthy				
Getting better				
Living with illness or disability				
End of life care				

- Equity is a component of health care quality that applies to all cells in the matrix
- Resource generation is another component discussed in the National Healthcare Report
- The first NHQR is due to Congress in 2003

Consumer Information Framework – 4 M’s

Key Components to Inform Current Approaches

- **Model*:*** to articulate priorities and organize quality information for decision-making
- **Messages*:*** to inform and empower key stakeholders to take action (consumers, purchasers, providers, policymakers)
- **Measures*:*** relevant, understandable evaluations of health care performance maximizing and integrating all sources of data; iterative consideration of set and measure criteria
- **Methods:** Integrated case finding, sampling, data collection, scoring, grading and reporting methods

Consumer Information Framework

Component: Measurement Model

Model: *to articulate domains and organize quality information for decision-making*

- Topics (Goals of care; outcomes!)
- Type of measure (process, outcome, experience of care—OR--steps to good care; experience of care; results of good care)
- Unit of analysis (patient, practice, plan, medical group, state, nation, county, etc.)
- Population (ages, health status, race/ethnicity, etc.)

Consumer Information Framework

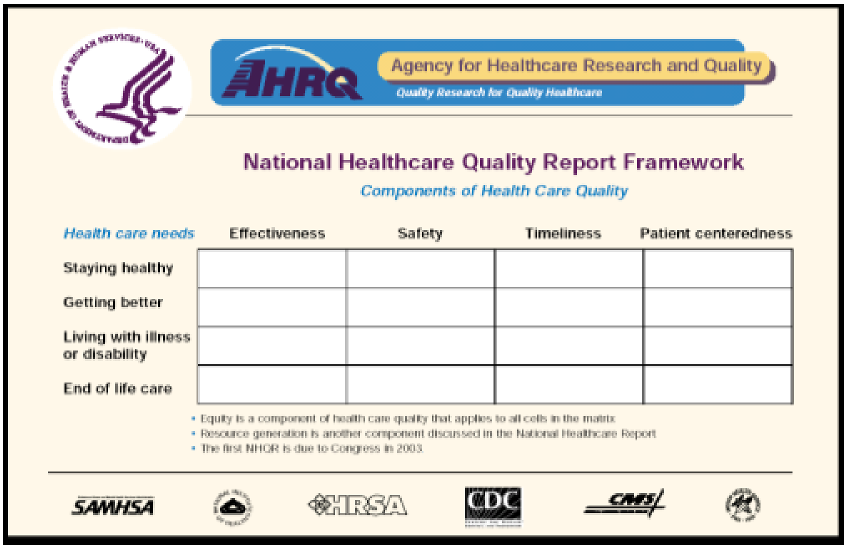
Measurement Model – What the CHIPRA Legislation Says

- **Topics (Goals of Care-Outcomes?)**
  - Clinical quality
  - Health Care Safety
  - Family Experience with Care
  - Health Care in the Most Integrated Setting
  - Elimination of Disparities

> “clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care.”
> -- **CHIPRA § 401, 123 Stat. 73**

- **Types of measure (process, outcome, experience of care)**
  - Structure of the Clinical Care System
  - Process of Care
  - Outcome of Care
  - Patient Experiences of Care

> “the term ‘pediatric quality measure’ means a measurement of clinical care… including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences of care.”
> -- **CHIPRA § 401, 123 Stat. 75**



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Consumer Information Framework

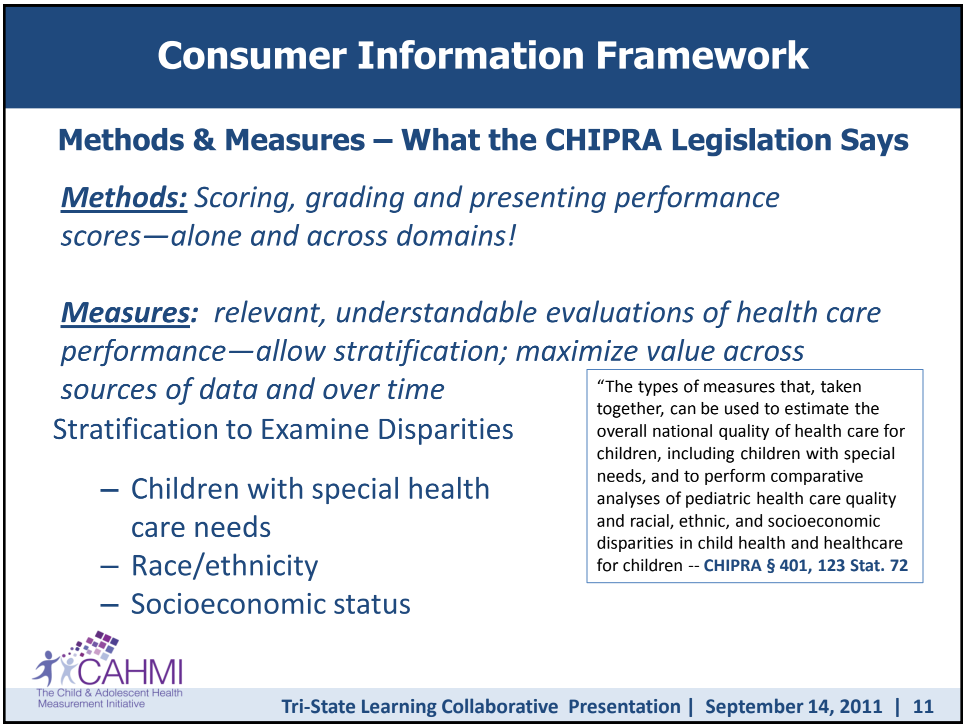
Messages – What the CHIPRA Legislation Says

***<u>Messages</u>*:** *to inform and empower key stakeholders to take action (establish interest, gain credibility, guide action)*

Messages for a broad range of audiences

- Purchasers
- Families
- Health Care Providers

Audiences Suggested by the CHIPRA legislation
"Allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic." -- **CHIPRA § 401, 123 Stat. 73**



Consumer Information Framework

Methods & Measures – What the CHIPRA Legislation Says

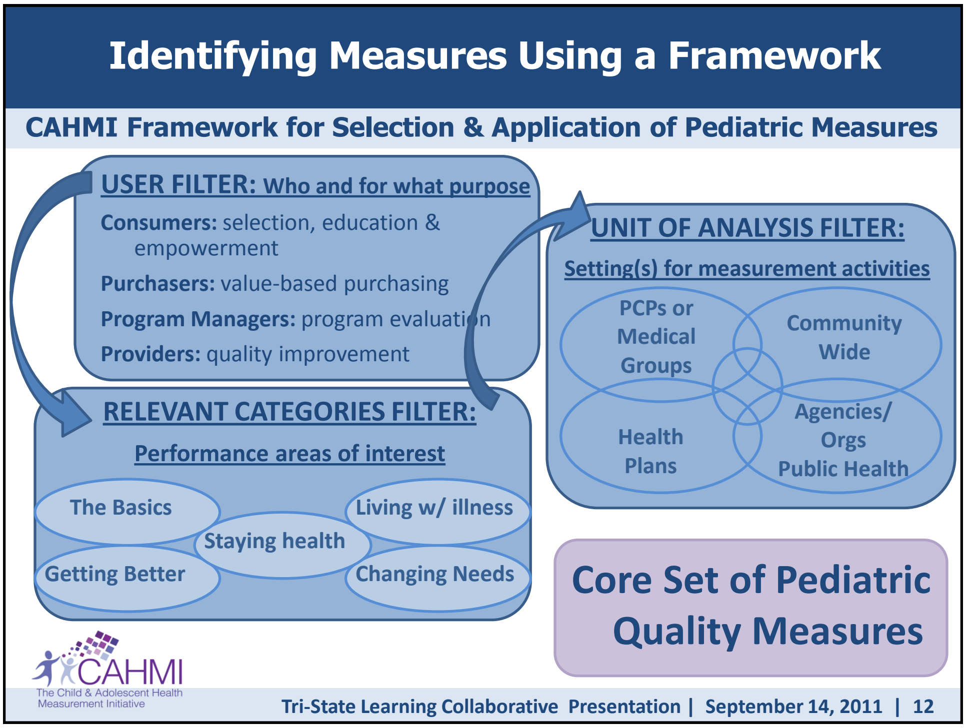
Methods: *Scoring, grading and presenting performance scores—alone and across domains!*

Measures: *relevant, understandable evaluations of health care performance—allow stratification; maximize value across sources of data and over time*

Stratification to Examine Disparities

- Children with special health care needs
- Race/ethnicity
- Socioeconomic status

> “The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and healthcare for children -- **CHIPRA § 401, 123 Stat. 72**



Identifying Measures Using a Framework

CAHMI Framework for Selection & Application of Pediatric Measures

USER FILTER: Who and for what purpose

Consumers: selection, education & empowerment

Purchasers: value-based purchasing

Program Managers: program evaluation

Providers: quality improvement

RELEVANT CATEGORIES FILTER:

Performance areas of interest

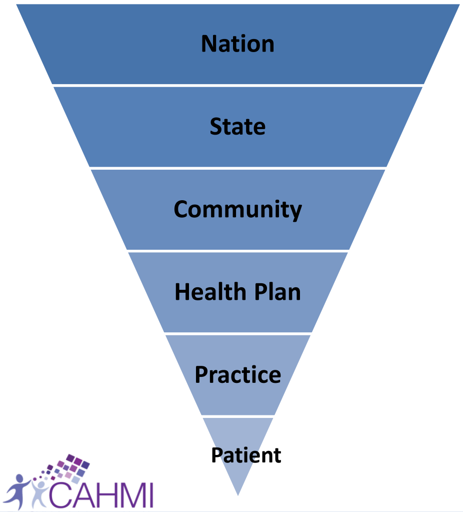
UNIT OF ANALYSIS FILTER:

Setting(s) for measurement activities

Core Set of Pediatric Quality Measures

Identification of Measures

Consider Measures that can be used at Multiple Levels



Nation

State

Community

Health Plan

Practice

Patient

- Used to collect data across geographic areas and system and service settings
- Yield data comparable across units of analysis and key subgroups
- Have benchmarks available
- Currently collected and have potential to be adapted through sampling strategies, etc. to yield more robust data for relevant subgroups

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Why Wait? Working with what we have available.

Using the National Survey Indicators

- National Survey of Children's Health (NSCH)
- National Survey of Children with Special Health Care Needs (NS-CSHCN)
- Both surveys are conducted using State and Local Area Integrated Telephone Survey (SLAITS)
  - Surveys are administered using Computer-Assisted Telephone Interviewing (CATI) Instruments

National Survey Data

Applying the Results at Multiple Levels

- Sampling weights permit national and state-specific estimates of health and well-being
  - Sub-state data for Rural/Urban areas is available on DRC website
  - Local – County estimates not available in the survey, however, synthetic estimates are possible!
- Weights are adjusted to match American Community Survey population totals for various demographic groups

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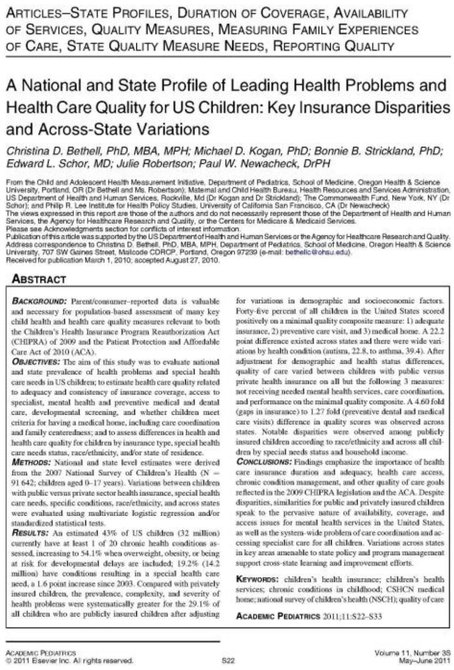
National and State Survey Data

Indicators by CHIPRA Core Measure Domain*

Prevention & Health Promotion	Availability**	Management of Acute Conditions	Management of Chronic Conditions	Family Experiences of Care
• Well Visits • Dental Visits • Developmental Surveillance • Developmental Screening • Immunizations (3 indicators)	• Mental health Care Access • Specialist Access	N/A	• CSHCN with unmet needs • CSHCN with unmet needs - family support services • CSHCN with difficulty getting referral	• Family-Centered Care

* All indicators available to be stratified by CSHCN, SES and Race/Ethnicity

** Also includes: Adequacy of Health Insurance and Consistency of Health Insurance



ARTICLES–STATE PROFILES, DURATION OF COVERAGE, AVAILABILITY OF SERVICES, QUALITY MEASURES, MEASURING FAMILY EXPERIENCES OF CARE, STATE QUALITY MEASURE NEEDS, REPORTING QUALITY

A National and State Profile of Leading Health Problems and Health Care Quality for US Children: Key Insurance Disparities and Across-State Variations

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The views expressed in this report are those of the authors and do not necessarily represent those of the Department of Health and Human Services, the Agency for Healthcare Research and Quality, or the Centers for Medicare & Medicaid Services.

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ABSTRACT

BACKGROUND: Parent/consumer–reported data is valuable and necessary for population-based assessment of many key child health and health care quality measures relevant to both the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Patient Protection and Affordable Care Act of 2010 (ACA).

OBJECTIVES: The aim of this study was to evaluate national and state prevalence of health problems and special health care needs in US children; to estimate health care quality related to adequacy and consistency of insurance coverage, access to specialist, mental health and preventive medical and dental care, developmental screening, and whether children meet criteria for having a medical home, including care coordination and family centeredness; and to assess differences in health and health care quality for children by insurance type, special health care needs status, race/ethnicity, and/or state of residence.

METHODS: National and state level estimates were derived from the 2007 National Survey of Children's Health (N = 91 642; children aged 0–17 years). Variations between children with public versus private sector health insurance, special health care needs, specific conditions, race/ethnicity, and across states were evaluated using multivariate logistic regression and/or standardized statistical tests.

RESULTS: An estimated 43% of US children (32 million) currently have at least 1 of 20 chronic health conditions assessed, increasing to 54.1% when overweight, obesity, or being at risk for developmental delays are included; 19.2% (14.2 million) have conditions resulting in a special health care need, a 1.6 point increase since 2003. Compared with privately insured children, the prevalence, complexity, and severity of health problems were systematically greater for the 29.1% of all children who are publicly insured children after adjusting for variations in demographic and socioeconomic factors. Forty-five percent of all children in the United States scored positively on a minimal quality composite measure: 1) adequate insurance, 2) preventive care visit, and 3) medical home. A 22.2 point difference existed across states and there were wide variations by health condition (autism, 22.8, to asthma, 39.4). After adjustment for demographic and health status differences, quality of care varied between children with public versus private health insurance on all but the following 3 measures: not receiving needed mental health services, care coordination, and performance on the minimal quality composite. A 4.60 fold (gaps in insurance) to 1.27 fold (preventive dental and medical care visits) difference in quality scores was observed across states. Notable disparities were observed among publicly insured children according to race/ethnicity and across all children by special needs status and household income.

CONCLUSIONS: Findings emphasize the importance of health care insurance duration and adequacy, health care access, chronic condition management, and other quality of care goals reflected in the 2009 CHIPRA legislation and the ACA. Despite disparities, similarities for public and privately insured children speak to the pervasive nature of availability, coverage, and access issues for mental health services in the United States, as well as the system-wide problem of care coordination and accessing specialist care for all children. Variations across states in key areas amenable to state policy and program management support cross-state learning and improvement efforts.

KEYWORDS: children's health insurance; children's health services; chronic conditions in childhood; CSHCN medical home; national survey of children's health (NSCH); quality of care

ACADEMIC PEDIATRICS 2011;11:S22–S33

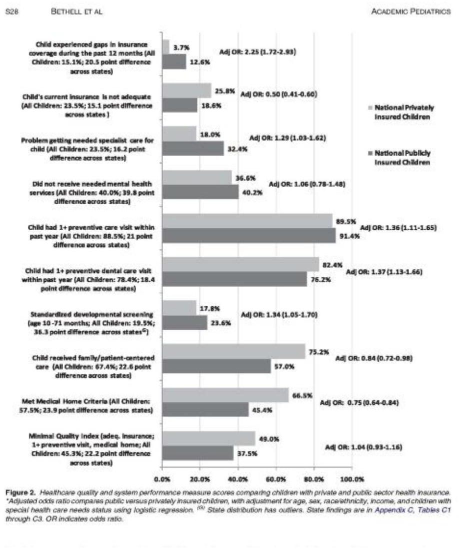
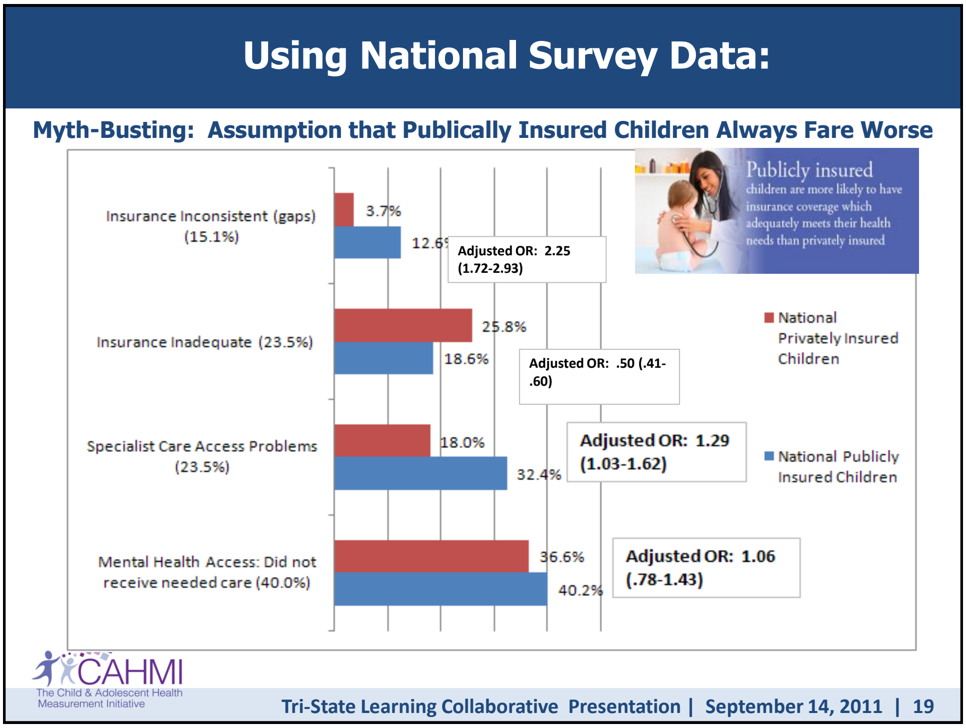


Figure 2. *Healthcare quality and system performance measure scores comparing children with private and public sector health insurance. *Adjusted odds ratio compares public versus privately insured children, with adjustment for age, sex, race/ethnicity, income, and children with special health care needs status using logistic regression. (G) State distribution has outliers. State findings are in Appendix C, Tables C1 through C3. OR indicates odds ratio.*



Using National Survey Data:

Myth-Busting: Assumption that Publically Insured Children Always Fare Worse

Adjusted OR: 2.25 (1.72-2.93)

Adjusted OR: .50 (.41-.60)

Adjusted OR: 1.29 (1.03-1.62)

Adjusted OR: 1.06 (.78-1.43)

Publicly insured children are more likely to have insurance coverage which adequately meets their health needs than privately insured

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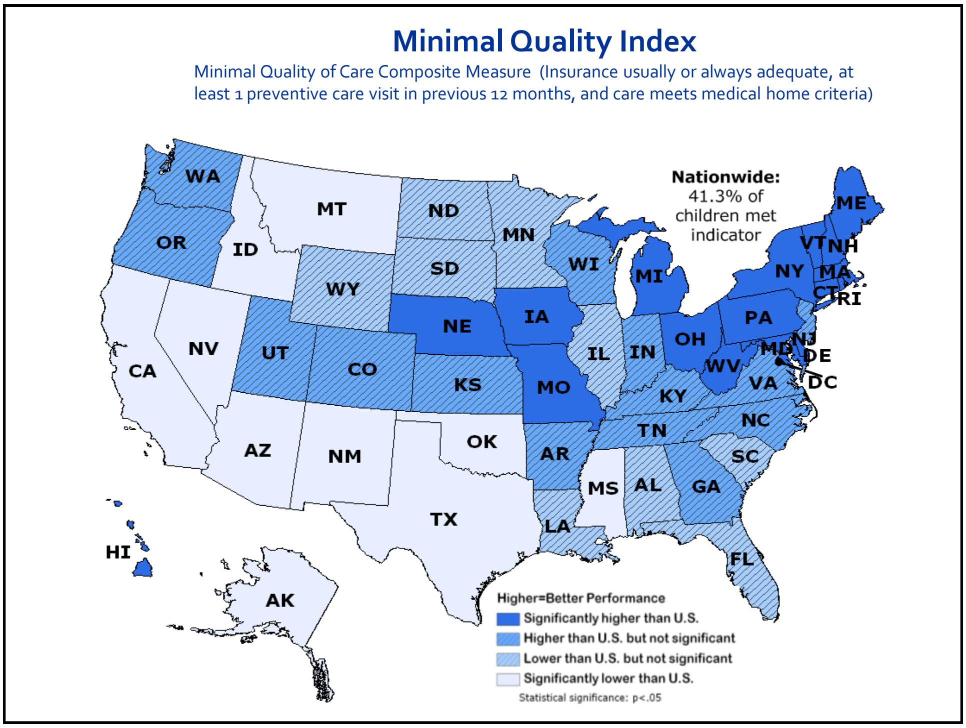


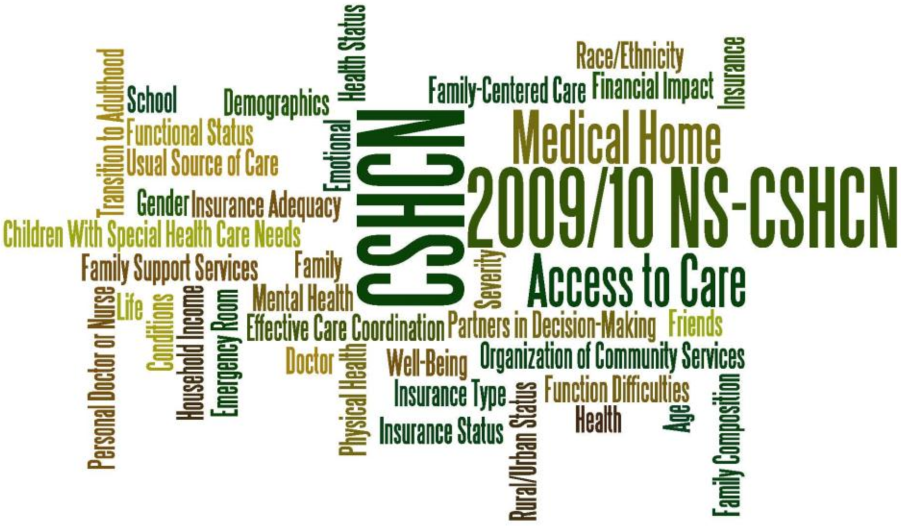
Minimal Quality Index

Minimal Quality of Care Composite Measure (Insurance usually or always adequate, at least 1 preventive care visit in previous 12 months, and care meets medical home criteria)

Nationwide: 41.3% of children met indicator

Higher=Better Performance
- Significantly higher than U.S.
- Higher than U.S. but not significant
- Lower than U.S. but not significant
- Significantly lower than U.S.

Statistical significance: p<.05



Overview of the National Surveys

National Survey of Children with Special Health Care Needs (2005/06 & upcoming 09/10)

- Topic Areas: MCHB Core Outcomes and Indicators, Health and Functional Status, Utilization and Unmet Needs, Care Coordination, Family-Centered Care, Transition Issues, Ease of Service Use, Insurance Status, Adequacy of Insurance Coverage, and Impact on the Family.
- Previously conducted in 2001
- Awaiting public release of 2009/10 data

Key Topics Available in NSCH (cont.)

- **Health Care Quality and Equity**
  - Medical home for all children and children and youth with special health care needs
  - Health disparities for vulnerable populations (minorities, low income, by health status/CSHCN)
- **Community and School Activities**
- **Family Health and Activities**
- **Neighborhood Safety and Support**

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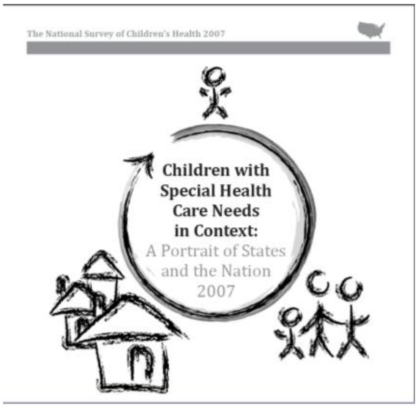
Illustration: Leverage the NSCH to create a unique synthesis of nationally comparable data


The National Survey of Children's Health 2007

Children with Special Health Care Needs in Context: A Portrait of States and the Nation 2007

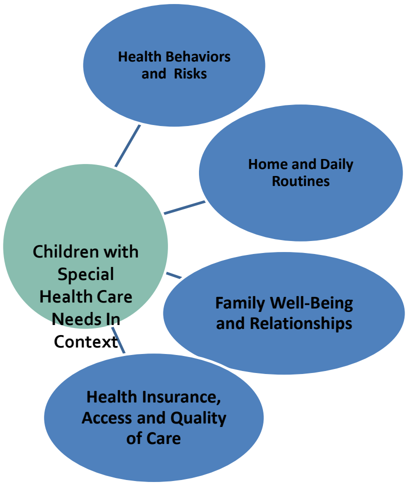


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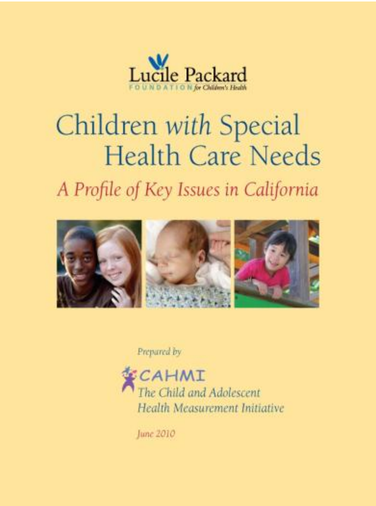
Illustration: Leverage both the NS CSHCN and NSCH to create a unique synthesis of nationally comparable data


Lucile Packard FOUNDATION for Children's Health

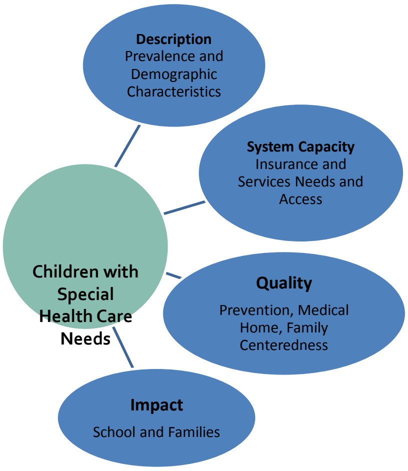
Children with Special Health Care Needs

A Profile of Key Issues in California

Prepared by

CAHMI *The Child and Adolescent Health Measurement Initiative*

June 2010



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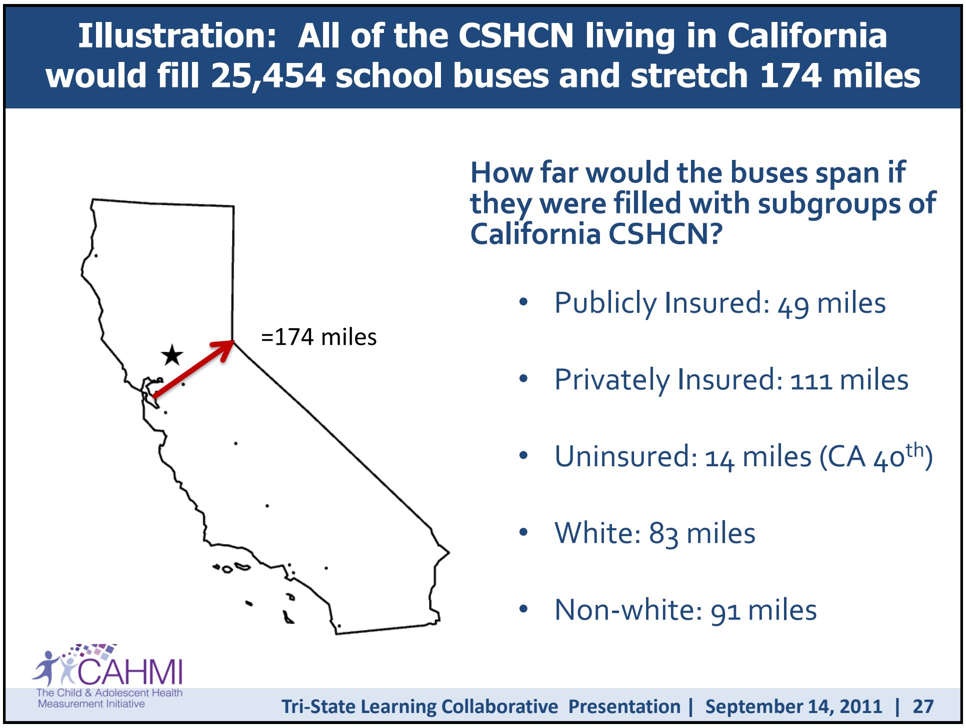

Illustration: All of the CSHCN living in California would fill 25,454 school buses and stretch 174 miles

How far would the buses span if they were filled with subgroups of California CSHCN?

- Publicly Insured: 49 miles
- Privately Insured: 111 miles
- Uninsured: 14 miles (CA 40th)
- White: 83 miles
- Non-white: 91 miles

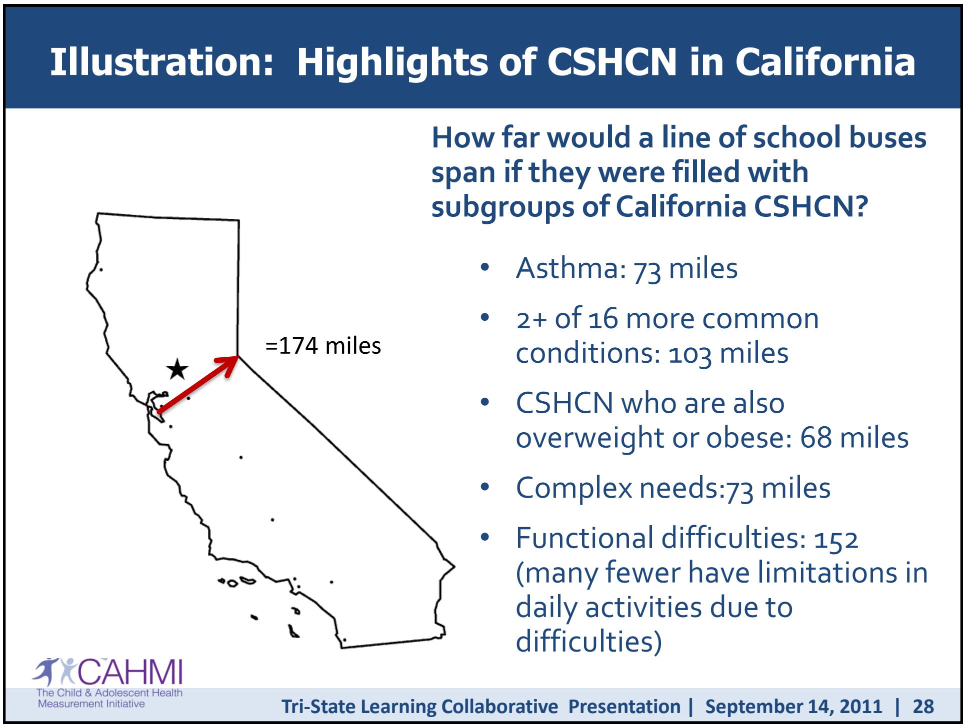

Illustration: Highlights of CSHCN in California

How far would a line of school buses span if they were filled with subgroups of California CSHCN?

- Asthma: 73 miles
- 2+ of 16 more common conditions: 103 miles
- CSHCN who are also overweight or obese: 68 miles
- Complex needs:73 miles
- Functional difficulties: 152 (many fewer have limitations in daily activities due to difficulties)

Illustration

- **573,000 CSHCN** in CA have asthma, which is the equivalent of enough children to fill *30 Staples Centers!*
  - *29 for CSHCN with 2+ conditions*
  - *20 for CSHCN with emotional, developmental or behavioral health issues*
  - *17 for ADHD*
  - *3.35 for Autism/ASD*
  - *1.88 for Cerebral Palsy*
  - *1.52 for Epilepsy*
  - *.78 for Diabetes*
  - *.57 for Down Syndrome*

We all know availability of data does not equal access or effective use of data

Meaningful Data Available

Simple and Usable Quick Access Mechanisms

Application and Interpretation Assistance

Publicly insured children are more likely to have insurance coverage which adequately meets their health needs than privately insured

Data at a Glance

At your fingertips–easy-to-read data snapshots for each state

Welcome to the Data Resource Center for Child & Adolescent Health!

Welcome to the newly redesigned DRC website. Take a tour of the site and give us your feedback.

The mission of the Data Resource Center (DRC) is to take the voices of parents, gathered through the National Survey of Children's Health (NSCH) and the National Survey of Children with Special Health Care Needs (NS-CSHCN), and share the results through this online resource so they can be used by researchers, policymakers, family advocates and consumers to promote a higher quality health careeeee system for children, youth and families. ⏩Learn more about the DRC

DRC Highlights

- Child Obesity State Report Cards
- New NS-CSHCN Data Trends
- New chartbook comparing CSHCN with children who do not have special health care needs

Most Popular Topics

What you can do on the DRC website?

- **Learn about** the National Survey of Children's Health and the National Survey of Children with Special Health Care Needs
- **Browse** national and state findings on hundreds of child health indicators
- **Search** data based on numerous important topics and subgroups of children
- **Download** and print snapshot profiles on key

Connect with the DRC

Sign up for email updates

childhealthdata National study finds that providing insurance to the poor helps them maintain both health and financial stability: http://t.co/y0X8Hlb
4 days ago · reply · retweet · favorite

childhealthdata 1 in 5 high school students meets the medical criteria for addiction, according to a Columbia study. Read an article at http://t.co/a3ox4H2
6 days ago · reply · retweet · favorite

DRC
A project of CAHMI

What Data are Available on the DRC Website

- Data Snapshots
  - View Multiple Indicators from each survey
  - Compare Multiple Indicators Across Years
  - View Topic Specific Snapshots
- Individual Indicators
  - Available by state, region, and nationwide
  - Can be stratified by subgroups
  - Compare all states on individual indicators
- State Ranking Maps

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Ask us a question | Request a dataset

Open your data briefcase

Your Data ... Your Story

Data Resource Center for Child & Adolescent Health

A project of the Child and Adolescent Health Measurement Initiative

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State/Region: Nationwide

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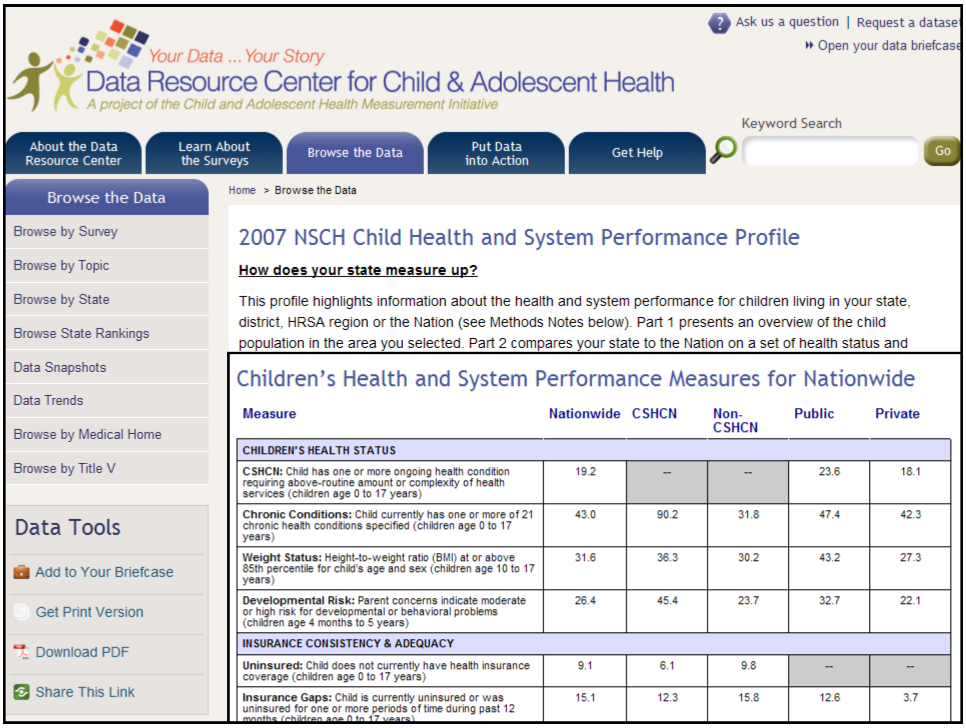

Ask us a question | Request a dataset

Open your data briefcase

Your Data ... Your Story

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Browse the Data

- Browse by Survey
- Browse by Topic
- Browse by State
- Browse State Rankings
- Data Snapshots
- Data Trends
- Browse by Medical Home
- Browse by Title V

Data Tools

- Add to Your Briefcase
- Get Print Version
- Download PDF
- Share This Link

Home > Browse the Data

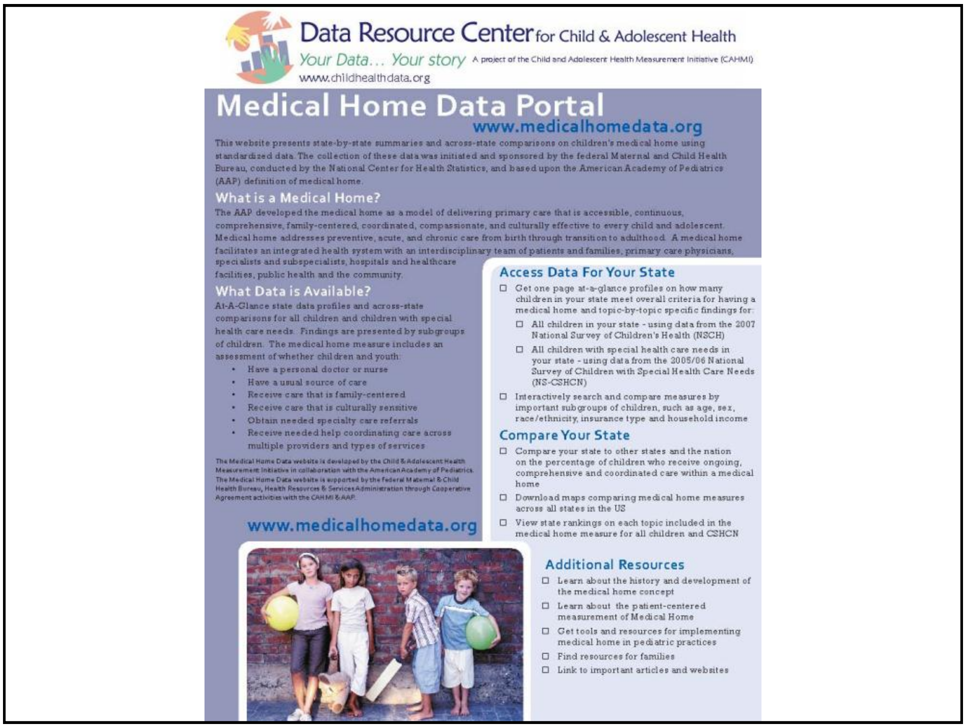
2007 NSCH Child Health and System Performance Profile

How does your state measure up?

This profile highlights information about the health and system performance for children living in your state, district, HRSA region or the Nation (see Methods Notes below). Part 1 presents an overview of the child population in the area you selected. Part 2 compares your state to the Nation on a set of health status and

Children's Health and System Performance Measures for Nationwide

Measure	Nationwide	CSHCN	Non-CSHCN	Public	Private
CHILDREN'S HEALTH STATUS					
CSHCN: Child has one or more ongoing health condition requiring above-routine amount or complexity of health services (children age 0 to 17 years)	19.2	--	--	23.6	18.1
Chronic Conditions: Child currently has one or more of 21 chronic health conditions specified (children age 0 to 17 years)	43.0	90.2	31.8	47.4	42.3
Weight Status: Height-to-weight ratio (BMI) at or above 85th percentile for child's age and sex (children age 10 to 17 years)	31.6	36.3	30.2	43.2	27.3
Developmental Risk: Parent concerns indicate moderate or high risk for developmental or behavioral problems (children age 4 months to 5 years)	26.4	45.4	23.7	32.7	22.1
INSURANCE CONSISTENCY & ADEQUACY					
Uninsured: Child does not currently have health insurance coverage (children age 0 to 17 years)	9.1	6.1	9.8	--	--
Insurance Gaps: Child is currently uninsured or was uninsured for one or more periods of time during past 12 months (children age 0 to 17 years)	15.1	12.3	15.8	12.6	3.7



Data Resource Center for Child & Adolescent Health

Your Data… Your story A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

www.childhealthdata.org

Medical Home Data Portal

www.medicalhomedata.org

This website presents state-by-state summaries and across-state comparisons on children's medical home using standardized data. The collection of these data was initiated and sponsored by the federal Maternal and Child Health Bureau, conducted by the National Center for Health Statistics, and based upon the American Academy of Pediatrics (AAP) definition of medical home.

What is a Medical Home?

The AAP developed the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent. Medical home addresses preventive, acute, and chronic care from birth through transition to adulthood. A medical home facilitates an integrated health system with an interdisciplinary team of patients and families, primary care physicians, specialists and subspecialists, hospitals and healthcare facilities, public health and the community.

What Data is Available?

At-A-Glance state data profiles and across-state comparisons for all children and children with special health care needs. Findings are presented by subgroups of children. The medical home measure includes an assessment of whether children and youth:

- Have a personal doctor or nurse
- Have a usual source of care
- Receive care that is family-centered
- Receive care that is culturally sensitive
- Obtain needed specialty care referrals
- Receive needed help coordinating care across multiple providers and types of services

The Medical Home Data website is developed by the Child & Adolescent Health Measurement Initiative in collaboration with the American Academy of Pediatrics. The Medical Home Data website is supported by the federal Maternal & Child Health Bureau, Health Resources & Services Administration through Cooperative Agreement activities with the CAHMI & AAP.

www.medicalhomedata.org

Access Data For Your State

☐ Get one page at-a-glance profiles on how many children in your state meet overall criteria for having a medical home and topic-by-topic specific findings for:
  ☐ All children in your state - using data from the 2007 National Survey of Children's Health (NSCH)
  ☐ All children with special health care needs in your state - using data from the 2005/06 National Survey of Children with Special Health Care Needs (NS-CSHCN)
☐ Interactively search and compare measures by important subgroups of children, such as age, sex, race/ethnicity, insurance type and household income

Compare Your State

☐ Compare your state to other states and the nation on the percentage of children who receive ongoing, comprehensive and coordinated care within a medical home
☐ Download maps comparing medical home measures across all states in the US
☐ View state rankings on each topic included in the medical home measure for all children and CSHCN

Additional Resources

☐ Learn about the history and development of the medical home concept
☐ Learn about the patient-centered measurement of Medical Home
☐ Get tools and resources for implementing medical home in pediatric practices
☐ Find resources for families
☐ Link to important articles and websites

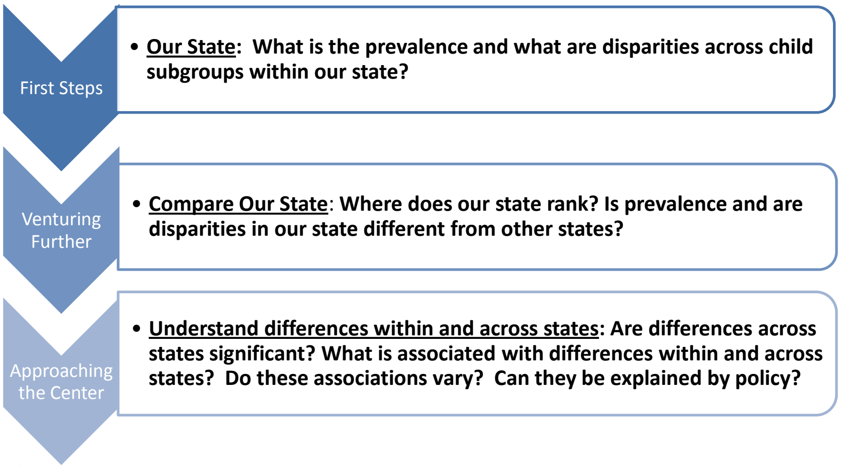
DRC
A project of CAHMI

How the Data Resource Center Can Support Improvement Partnerships

Understand your population	User generated tables, bar and pie charts, and customizable reports supply prevalence estimates and population counts to help define your population of CSCHN and their health needs
Assess system performance	Immediate access to over 100 state-specific indicators of child health and well-being and system performance for children overall and children with special health care needs (CSHCN).
Examine improvement opportunities	"Point and click" menu allows users to explore disparities and gaps in access and services for different population subgroups of children and CSHCN.
Select priorities	User generated tables, bar and pie charts, and customizable reports supply prevalence estimates and population counts to help guide selection of priority needs.
Set targets	"All States" ranking maps and tables provide benchmark data to assist in identifying state-negotiated performance measure targets.
Identify promising improvement models	Information on national, within and across States variation using standardized indicators helps identify where quality is better and can help in cross-state learning for purposes of identifying promising models for improvement as well as identify key collaborators for improvement.
Monitor progress	Centralized resource for standardized, population-based survey questions to use in collecting child health and health care quality data locally.

Using the National Survey Data for State-Level QI

Progression Through the Data Labyrinth



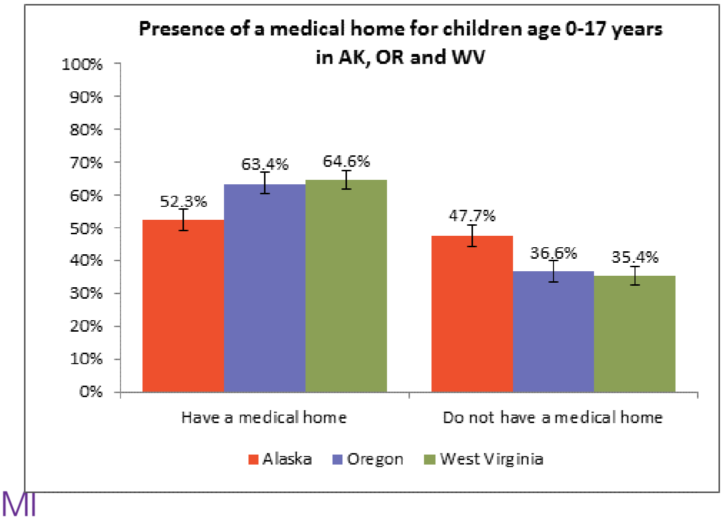
- <u>Our State</u>: What is the prevalence and what are disparities across child subgroups within our state?

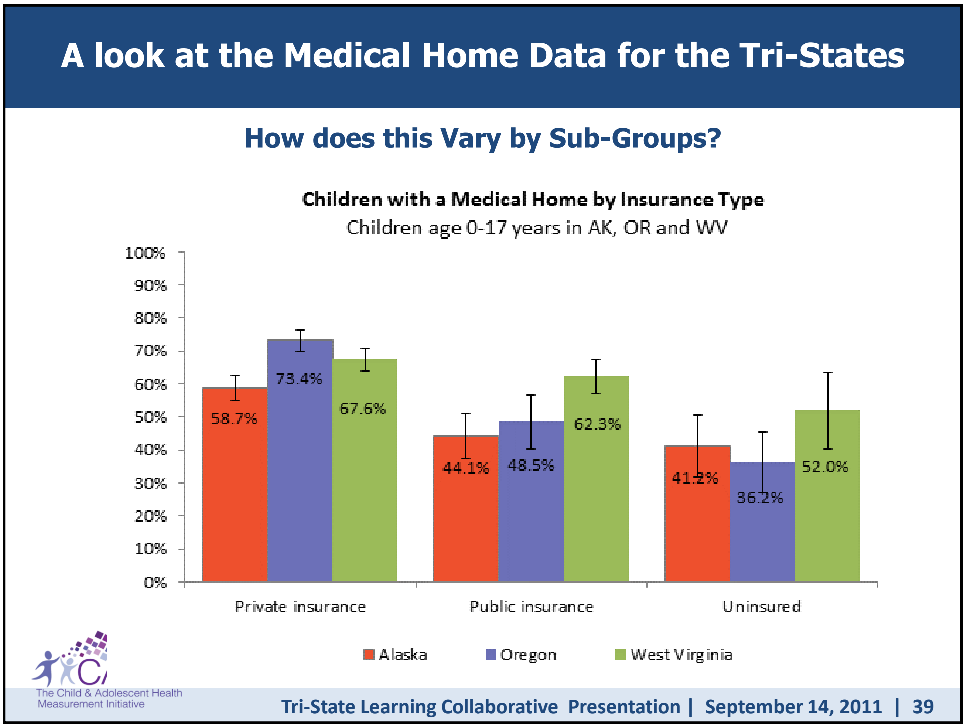
- <u>Compare Our State</u>: Where does our state rank? Is prevalence and are disparities in our state different from other states?

- <u>Understand differences within and across states</u>: Are differences across states significant? What is associated with differences within and across states? Do these associations vary? Can they be explained by policy?

A look at the Medical Home Data for the Tri-States

What percentage of children have a Medical Home in our states?





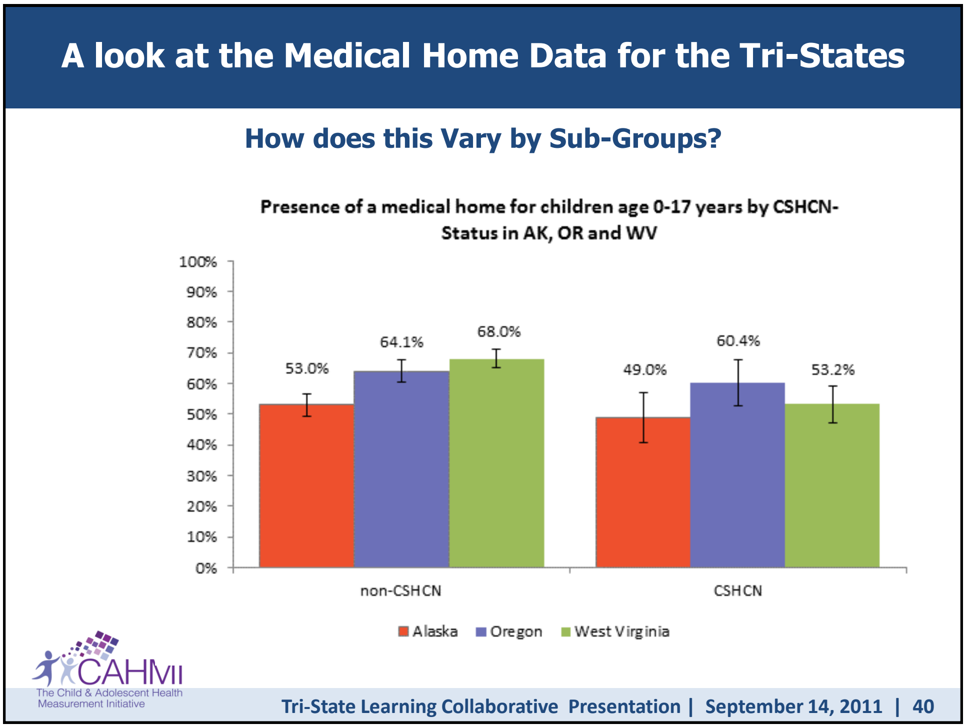
A look at the Medical Home Data for the Tri-States

How does this Vary by Sub-Groups?

Children with a Medical Home by Insurance Type

Children age 0-17 years in AK, OR and WV

The Child & Adolescent Health Measurement Initiative



A look at the Medical Home Data for the Tri-States

How does this Vary by Sub-Groups?

Presence of a medical home for children age 0-17 years by CSHCN-Status in AK, OR and WV

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A look at the Medical Home Data for the Tri-States

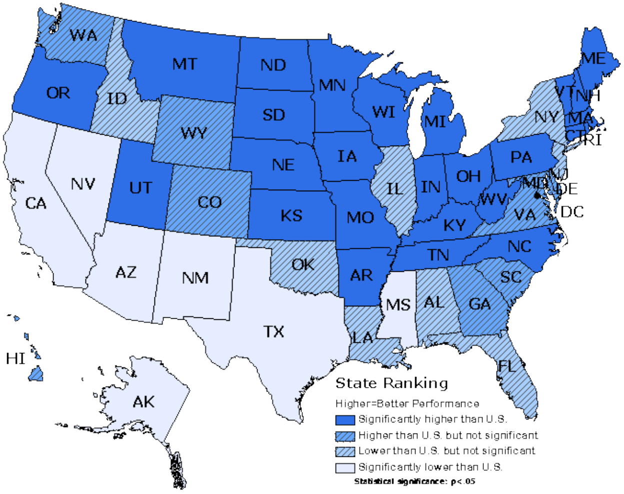
Where do our States Rank?

Percent of children with who received care within a medical home
2007 National Survey of Children's Health

Alaska: 52.3% (44th)

Oregon: 63.4% (12th)

West Virginia: 64.6% (9th)



State Ranking

Higher=Better Performance

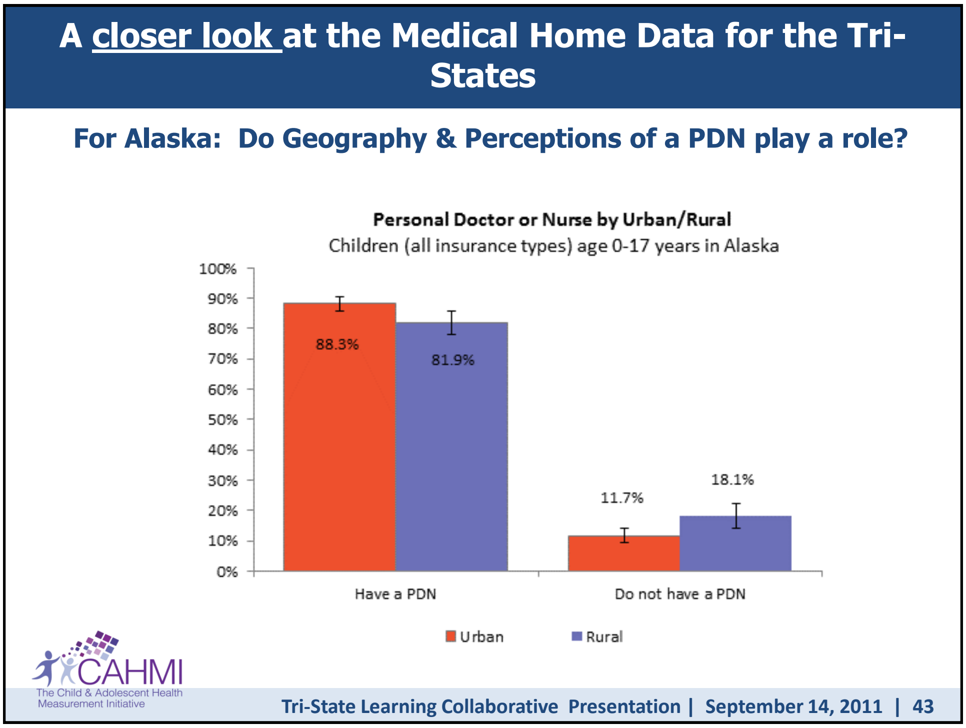
- 🟦 Significantly higher than U.S.
- ▨ Higher than U.S. but not significant
- ▨ Lower than U.S. but not significant
- ☐ Significantly lower than U.S.

Statistical significance: $p < .05$

A <u>closer look</u> at the Medical Home Data for the Tri-States

What percentage of <u>publicly insured</u> meet the indicator criteria for Medical Home?

	Nation	AK	OR	WV
PDN: Child has personal doctor or nurse (PDN) who knows child and family well and is familiar with child's health history	**90.8%**	**83.6%** **51st**	**91.2%** **23rd**	**94.1%** **8th**
Usual Source of Care: Child usually goes to a specific clinic, doctor's office, or other place for medical treatment or advice when ill	**90.5%**	**92.6%** **22nd**	**92.7%** **21st**	**96.4%** **3rd**
Family-Centered Care: Parent reports a trusting, collaborative, working partnership with child's health providers	**57.0%**	**59.8%** **29th**	**59.9%** **28th**	**73.5%** **4th**
No Problems getting Referrals: Child needed a referral in the previous 12 months and had no problems getting it	**76.1%**	**76.8%** **28th**	**70.4%** **39th**	**85.7%** **11th**
Effective Care Coordination: Family received all care coordination wanted and is satisfied with communication among providers and with schools	**62.7%**	**58.2%** **40th**	**60.5%** **29th**	**65.0%** **19th**



A closer look at the Medical Home Data for the Tri-States

For Alaska: Do Geography & Perceptions of a PDN play a role?

Personal Doctor or Nurse by Urban/Rural

Children (all insurance types) age 0-17 years in Alaska

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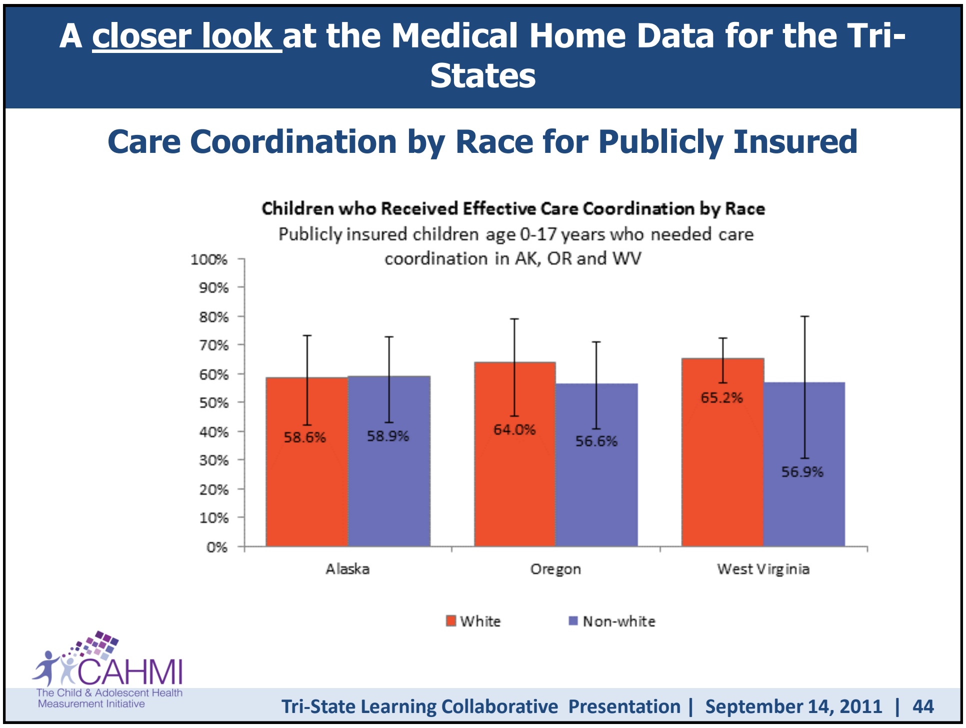

A closer look at the Medical Home Data for the Tri-States

Care Coordination by Race for Publicly Insured

Children who Received Effective Care Coordination by Race

Publicly insured children age 0-17 years who needed care coordination in AK, OR and WV

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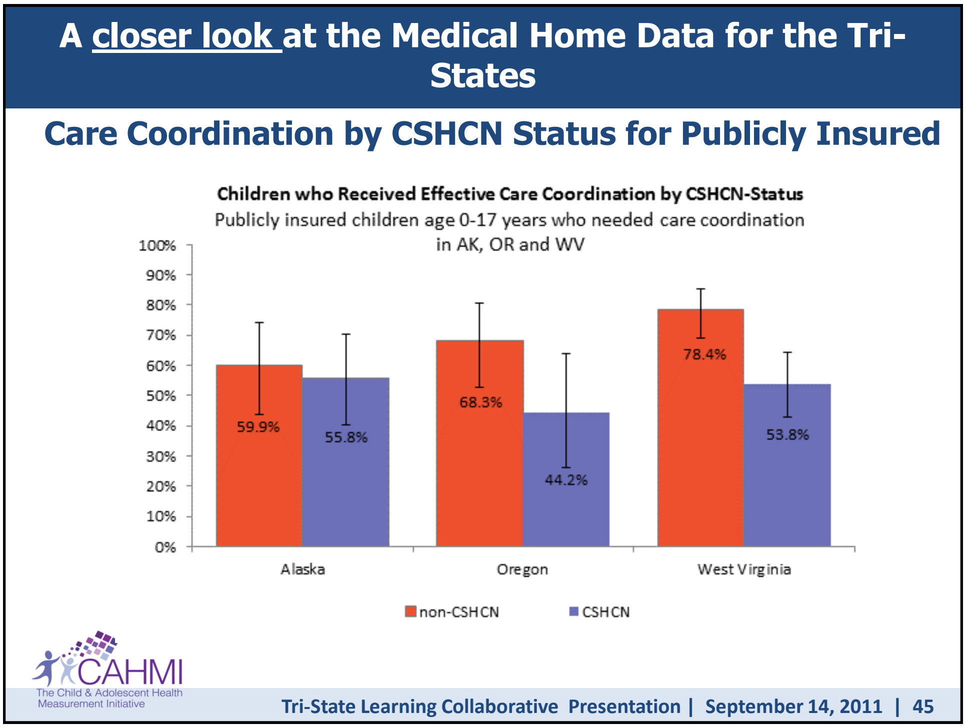
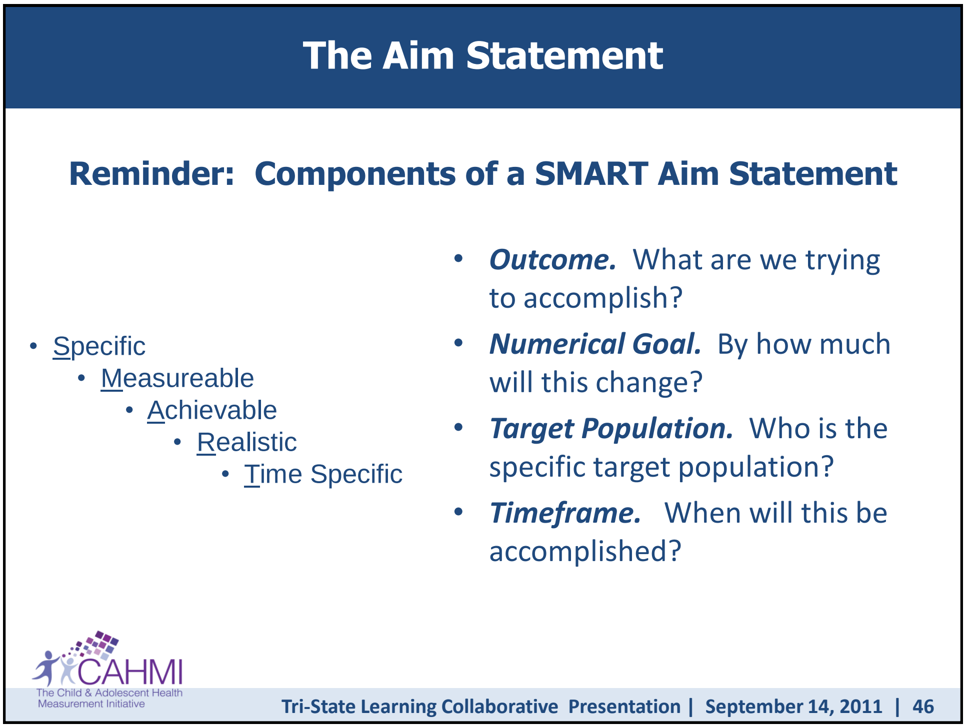


A closer look at the Medical Home Data for the Tri-States

Care Coordination by CSHCN Status for Publicly Insured

Children who Received Effective Care Coordination by CSHCN-Status

Publicly insured children age 0-17 years who needed care coordination in AK, OR and WV

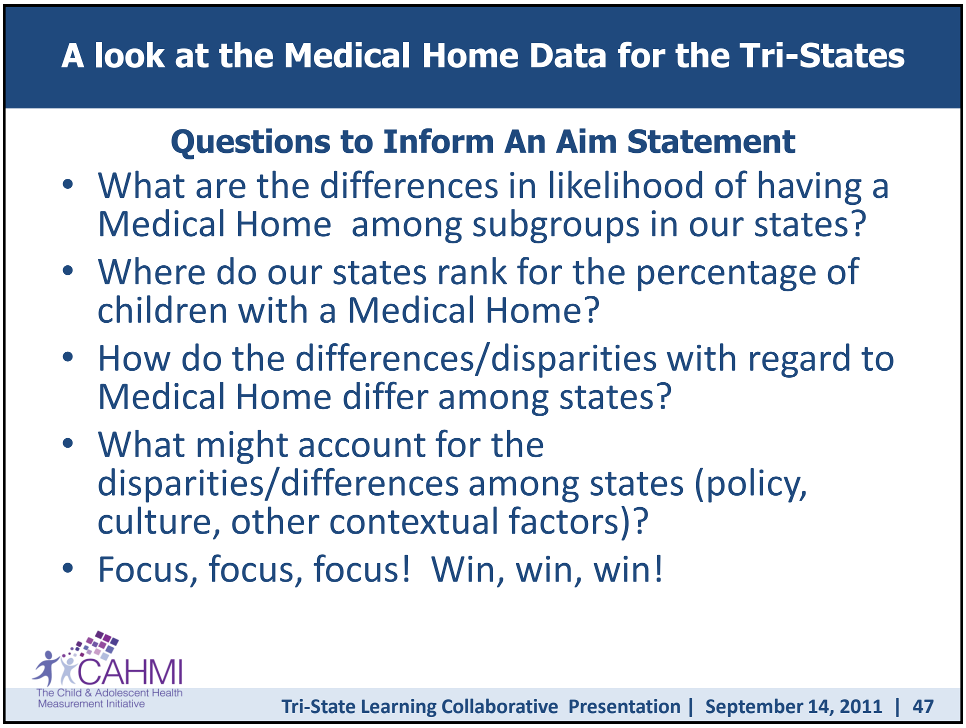


The Aim Statement

Reminder: Components of a SMART Aim Statement

- Specific
  - Measureable
    - Achievable
      - Realistic
        - Time Specific

- ***Outcome.*** What are we trying to accomplish?
- ***Numerical Goal.*** By how much will this change?
- ***Target Population.*** Who is the specific target population?
- ***Timeframe.*** When will this be accomplished?



A look at the Medical Home Data for the Tri-States

Questions to Inform An Aim Statement

- What are the differences in likelihood of having a Medical Home among subgroups in our states?
- Where do our states rank for the percentage of children with a Medical Home?
- How do the differences/disparities with regard to Medical Home differ among states?
- What might account for the disparities/differences among states (policy, culture, other contextual factors)?
- Focus, focus, focus! Win, win, win!