

SECTION 2: CATEGORY C – PROVIDER-BASED MODELS THAT IMPROVE THE DELIVERY OF CHILDREN’S HEALTHCARE

[Please note: References are listed on <http://www.odh.ohio.gov/landing/beacon/beacon.aspx>]

1. Mission, vision, and objectives, and how they align with CMS’s Grant Category C goals

We will development and implement a provider-based network model that uses collaborative quality improvement (QI) methods to dramatically improve Ohio’s prematurity and hospital-safety related child outcomes.¹⁻⁶ We build on two pioneering, sustainable learning networks, **Solutions for Patient Safety (SPS)** and the **Ohio Perinatal Quality Collaborative (OPQC)**. **SPS and OPQC** share related missions, visions and strategies to improve outcomes of hospitalized children. The **SPS** mission: eliminate harm to hospitalized children through use of collaborative QI. **SPS** vision: create a measurable change in the culture of safety at Ohio healthcare institutions. **OPQC** mission: reduce preterm births and improve outcomes of preterm infants. **OPQC** vision: all perinatal providers will use QI to improve outcomes of all 150,000 annual pregnancies. **SPS and OPQC together** will build on enduring partnerships and successes to create sustainable QI infrastructure. Both use collaborative QI based on the Institute for Healthcare Improvement’s Breakthrough Series model,⁷ employ standardized data definitions aligned with national and state measures, and are designed to align goals and leadership to transform the multiple layers of the delivery system (Section 1, Figure 1). The aims of the SPS and OPQC projects align fully with CMS Category C objectives:

Category C – SMART Aims	CMS Category C Objectives
SPS	
<i>Aim 1</i> – Reduce serious safety events (SSE) by 50% by year 3 and 75% by year 5. SSE is defined as variation from standard care resulting in serious harm due to either errors of commission or omission.	<p>Objective 1: To demonstrate that a provider-based model of care to improve the quality of children’s healthcare, especially children with special healthcare needs, can be implemented</p> <p>Objective 2: To learn how best to implement provider-based models of care, and identify barriers and how they can be overcome.</p> <p>Objective 3: To determine the impact of provider-</p>

	based models of care on healthcare quality, especially children with special healthcare needs
<i>Aim 2</i> – Reduce and sustain a 50% reduction in all serious harm, including hospital-acquired infections (surgical, ventilator, catheter-associated, blood stream) and severe adverse drug events (ADEs).	<p>Objective 1: To demonstrate that a provider-based model of care to improve the quality of children’s healthcare, especially children with special healthcare needs, can be implemented</p> <p>Objective 2: To learn how best to implement provider-based models of care, and identify barriers and how they can be overcome.</p> <p>Objective 3: To determine the impact of provider-based models of care on healthcare quality, especially children with special healthcare needs</p>
<i>Aim 3</i> – Establish stable QI infrastructure to enable provider-driven improvement by building improvement capability.	<p>Objective 1: To demonstrate that a provider-based model of care to improve the quality of children’s healthcare, especially children with special healthcare needs, can be implemented</p>
OPQC	
<i>Aim 1</i> – Develop/implement a statewide data management and QI infrastructure that includes all Ohio maternity and children’s hospitals. This infrastructure will be used first to disseminate OPQC’s successful project to reduce unnecessary elective deliveries from the 20 current to all 121 Ohio maternity hospitals, with the goal of reducing the rate of scheduled (elective) deliveries to <5% of births.	<p>Objective 1: To demonstrate that a provider-based model of care to improve the quality of children’s healthcare, especially children with special healthcare needs, can be implemented</p> <p>Objective 2: To learn how best to implement provider-based models of care, and identify barriers and how they can be overcome.</p> <p>Objective 3: To determine the impact of provider-based models of care on healthcare quality, especially children with special healthcare needs</p>
<i>Aim 2</i> – Disseminate OPQC’s successful NICU-associated infection project from 24 NICUs (50% of Ohio’s preterm infants) to hospitals caring for the remaining 50%, with the goal of reducing NICU associated infection rates to <5%.	<p>Objective 2: To learn how best to implement provider-based models of care, and identify barriers and how they can be overcome.</p> <p>Objective 3: To determine the impact of provider-based models of care on children’s healthcare quality, especially children with special healthcare needs</p>
<i>Aim 3</i> – Better understand and eliminate disparities in pregnancy outcomes across Ohio.	<p>Objective 2: To learn how best to implement provider-based models of care, and identify barriers and how they can be overcome</p>
<i>Aim 4</i> – Select and plan implementation of new perinatal topics of improvement.	<p>Objective 3: To determine the impact of provider-based models of care on healthcare quality, especially children with special healthcare needs</p>

BEACON Category C is strongly connected and integrated with Categories A (performance metrics for perinatal, neonatal, and hospital-acquired infections), B (data quality infrastructure) and E (multi-provider, cross-system, statewide network of clinicians linked with hospital-based support and use of QI). SPS and OPQC shared infrastructure will benefit Category E activities.

2. Strategies that will be used to achieve each objective

OPQC and SPS together support learning networks of clinical teams that use QI and high reliability organization theories. The QI framework includes shared data, collaborative learning, repetitive testing⁸ and feedback, and a relentless focus on health outcomes. **SPS** will have 3 phases for SSE reduction. **1. Planning - baseline evaluation** (8 months): **SPS** will address several components necessary to a sustainable learning network: (1) *Build will for transformation* through leadership meetings with CEOs, legal departments and boards of trustees of all eight Ohio children's hospitals; (2) *Conduct a diagnostic assessment* that includes (a) review of the last 2 years' SSEs to *create a common cause database*, (b) *interviews of 30 key stakeholders* at each site, and (c) a *safety culture survey* based on tools developed by AHRQ. SSEs are deviations from standard care resulting in severe harm, such as wrong site surgery or cardiac arrest from unrecognized deterioration. Preliminary Ohio data show 850 adverse drug events/month across 8 children's hospitals, with 1-2% of patients experiencing serious harm. We focus on SSEs because of the potential devastating harm and because pilot efforts at a single site have demonstrated sustained success in reducing SSEs and measurably improving organizational safety culture; and (3) Form a patient safety organization (PSO) that includes each hospital, with an action plan for each site and the state. **SPS and OPQC** will develop reports and operational plans, in consultation with the BEACON Council, for submission to CMS. **2. Implementation - Aims 1 and 2** (through year 3): Interventions to reduce serious harm, based on preliminary

results and diagnostic assessment, likely will focus on SSEs, hospital-acquired infections, and ADEs. Interventions will be individualized at each hospital. **SPS and OPQC will use the QI learning collaborative model** for implementing interventions: 9-18 months of learning and action, bringing together improvement teams from each site to achieve rapid improvements.⁷⁻⁹ Content experts, change packages, data collection, reporting, and analytic assistance are provided. Teams meet to learn about QI, implement local changes, and share successes and failures. The QI collaborative process has face-to-face learning sessions, monthly conference calls, site visits, individual calls with hospital team leaders, and milestone review sessions. Changes in SSEs will be tracked on run charts showing events per 10,000 adjusted patient days and days between events. Trained SSE reduction experts from successful pilot sites and the safety industry will provide consultation to each site. Work with hospital senior executive and lawyers will identify governance best practices and achieve transparency for SSE focus and accountability. **3. Expansion – Aim 3**, (years 4 and 5): **SPS and OPQC** will establish a stable QI infrastructure to enable provider-driven improvement by building improvement capability at all levels of the member hospitals, including data infrastructure. Using common learning sessions to train providers and improvement coaches to spread QI methods and identifying best practices for simulation training, we will build QI capability and establish persistent learning networks. Based on pilot efforts, we anticipate sites will develop highly reliable interventions focused on increasing situational awareness (e.g., multiple daily huddles). We will monitor progress using control charts¹⁰ to track rates of all serious harm. **OPQC:** OPQC will significantly expand its data management and QI collaboration to include a much larger proportion of practitioners and continue to make population-level improvements in maternal/infant health. For July 2008 to March 2010, ODJFS has contracted with OPQC (CMS

Neonatal Transformation Grant) to implement collaborative QI. **OPQC** principles: (1) involve all perinatal providers and measure outcomes at the population-level, (2) build on lessons learned from successful OPQC projects, (3) include a providers in selecting topics for improvement using OPQC's tested decision matrix (see BEACON website), and (4) collaborate with ODH to use birth/death certificates for selected population-level measures. During the initial **Planning Phase**, **OPQC** will collaborate with **SPS** to: (1) *engage senior leadership*, (2) *provide control charts for all Ohio birth hospitals* on key perinatal measures (first birth c-sections, low birth weight, frequency/timing of prenatal care), including newly mandated Ohio perinatal performance measures, (3) begin work on *expanded data system*, and (4) design and begin outreach and *recruitment of all Ohio maternity hospitals*. These actions will develop the state infrastructure necessary for sustainability. **Implementation phase, Aim 1: SPS and OPQC** will develop and implement a statewide data management and QI infrastructure that includes *all* 127 Ohio maternity and children's hospitals. Efficiencies and shared learnings will result in acceleration of improvements already realized. The new infrastructure will be used first to disseminate, by 2012, **OPQC's** successful project to reduce unnecessary elective deliveries to all 121 Ohio maternity hospitals to less than 5%. Plans include providing access for all hospitals to a password-protected, secure extranet to which hospital-designated individuals will have access to their data, OPQC analyses and a listserv, blog and peer production function for communication and collaborative knowledge generation. **OPQC** will develop 3 tiers of membership for perinatal providers: (1) full, as members of active improvement collaboratives, (2) partial, as participants in data management activities only or (3) observers. With ODH, we will provide monthly control charts to all maternity hospitals on new state-mandated perinatal measures: (antenatal steroids, maternal transfer and cesarean sections) and help maternity

hospitals improve birth certificate data quality. Stepwise, we will recruit all 121 maternity hospitals by conducting regional information sessions. All maternity hospitals will receive control charts of their own state data. By understanding prior OPQC achievements, availability of QI support, and that OPQC is committed to helping improve state mandated measures, we are confident that practitioners will join OPQC. With increased participation, improvements in the health of mothers and infants can occur. We will develop a significantly enhanced **OPQC** data management infrastructure to address statewide QI targeting population health (see Category B and website). Using available hospital cost accounting systems, **SPS and OPQC will** evaluate return on investment (cost of QI minus costs avoided) for all projects. An OPQC abstract to the 2010 Pediatric Academic Societies shows that, for a NICU with 200 annual admissions using QI, 3-4 lives could be saved and \$618,000 in infection-related treatment costs could be avoided.

Aim 2: By 2012, using the same methods outlined in Aim 1, we will reduce Ohio's NICU-associated infection rate to less than 5% by expanding current OPQC interventions from the current 24 participating NICUs (50% of Ohio very preterm infants) to all NICUs (100% of very preterm infants). We will use birth certificates to determine site of hospital care for all Ohio preterm newborns and recruit all remaining NICUs as OPQC participants. **Aim 3:** We will work to better understand and eliminate disparities in pregnancy outcomes across Ohio, including Medicaid-insured vs. all others, race/ethnicity and selected demographics (e.g., rural vs. urban), by developing subpopulation-specific key drivers, analyses and interventions. We will continue to collaborate with Governor Strickland's Infant Mortality Task Force that has 'elimination of disparities' as a primary focus (<http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx>).

Aim 4: With participation of all members and using its tested decision matrix (see BEACON web site), OPQC will select/plan implementation of new clinical topics for improvement.

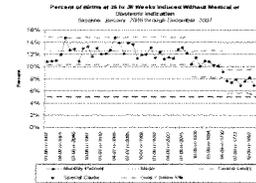
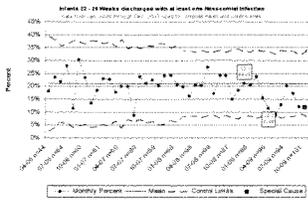
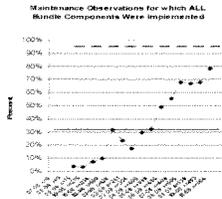
3. Expected degree of stakeholder involvement

The SPS project is led by a steering team consisting of representatives from the Ohio Children's Hospital Association (OCHA) and QI leaders from the 8 participating hospitals who meet by phone monthly and in person quarterly, and report to an executive team of all CEOs who meet regularly to oversee SPS. SPS works with the Ohio Business Round Table (OBRT), which sponsored a recent meeting of CEOs and board members, with particular attention to OBRT members who are also hospital board members. OPQC's Executive (decision making) and Steering (advisory) Committees comprise key clinicians, policymakers, healthcare organization administrators, professional organizations (Ohio chapters of the AAP and ACOG), researchers, QI experts, data managers, parents and state agencies (ODH, ODJFS). Reflecting its commitment to family-centered care, OPQC's Program Director/Executive Committee Chair is a mother of 18-year-old former 27-week triplets.

4. Evidence for implementation and sustainability of the proposed demonstration projects

Ohio has capacity to successfully implement the proposed projects: (a) provider-based learning network models for SPS and OPQC have been tested and are operational (although they will be extended as a key component of this proposal), (b) preliminary projects of these collaboratives have been very successful, and (c) outstanding buy-in and commitment from leaders and stakeholders at multiple levels to develop a sustainable infrastructure. OCHA QI leaders have led work resulting in development of public reporting measures for hospital-based pediatric care. SPS's initial project, launched in 2006, produced a 50% reduction in cardiac/respiratory arrests outside pediatric intensive care units (see <http://ohio-childrens-collaborative.qiteamspace.com> and <http://solutionsforpatientsafety.org/>). Preliminary data from a pilot hospital demonstrated a 70% reduction in surgical site infections. SPS is currently addressing SSIs and the use of trigger

tools to identify specific adverse drug events related to narcotics. OCHA has identified actions needed to transform from specific project work to a learning network of children's hospitals focused on QI and safety as core strategies. OCHA leadership engagement already exists, with its QI executive steering team meeting quarterly, the use of bi-annual joint board forums, CEO joint forums and joint legal department forums, and establishment of a QI leaders learning group dedicated to development of the group's QI expertise. The CEOs are committed to investing in QI infrastructure. The current and incoming chairs of OCHA's CEO Quality Committee have planned individual consultations with CEOs of the other 6 hospitals. Transparency concerns will be addressed by creation of a PSO. Data sharing agreements have been signed by all 8 hospitals. The need for extensive QI capability will be addressed by (1) using one pilot site with extensive QI experience that has worked locally and nationally on reducing SSEs, and (2) training improvement coaches who will work with **SPS and OPQC** in *all* Ohio maternity and children's hospitals, developing the infrastructure for sustainability. **OPQC** (www.opqc.net) is also operational, having launched its first 2 successful QI projects in September 2008. All 24 Ohio tertiary NICUs are using collaborative QI and evidence-based interventions to reduce infections. Reliable compliance with evidence-based catheter care has increased from 5% to 79% (Figure 1). For the 2 baseline years, the average NICU-associated infection rate for the 24 NICUs was 20%. From March to November 2009, the average monthly infection rate was 13% - a statistically significant 30% decrease in infections (Figure 2). **Figure 1:** Aggregate (24 NICUs) OPQC compliance with evidence-based catheter care, November 2009. **Figure 2:** Aggregate (24 NICUs) OPQC infection rate among 1,780 infants 22-29 weeks, November 2009. **Figure 3:** Aggregate (20 maternity hospitals) OPQC elective inductions of labor (n=4,181) and elective cesarean sections (n=3,059) at 36-38 weeks gestational age.



In the second project, 20 maternity hospitals accounting for 70,000 annual births (47% of all Ohio births) have decreased elective inductions of labor and cesarean sections at 36-38 weeks gestation. These hospitals have statistically significantly reduced inductions of labor at 37-38 weeks gestation by 75% - from 20% to less than 5% (Figure 3). **Together, these data indicate that Ohio will be able to implement and sustain the demonstration projects in Category C, and underscore the feasibility of the proposal.**

5. How the demonstration projects will answer National Evaluation questions

Category C's purpose is to evaluate the effectiveness of new or expanded provider-based models that: (1) measurably improve the quality of care provided to children covered by Medicaid/CHIP; (2) are supported by collaboration across multiple payers and stakeholder groups; (3) are cost-effective; and (4) result in systemic change and improvement to the delivery of healthcare for children. **Both SPS and OPQC** are actively pursuing these purposes. Ohio's Category C BEACON model utilizes multi-provider, cross-system, statewide networks of clinicians linked with hospital-based support systems, evidence-based improvement and reliability science methods. **SPS and OPQC's** improvement projects are focused on improving health outcomes by improving the delivery of evidence-based care. **Together, these projects will impact over 400,000 patient days, 60,000 admissions, 80,000 surgeries and 120,000 NICU days.** Improvements are unlikely without very specific measures of success. The projects measure monthly both quality of care and health outcomes. Hospital-specific, confidential reports, updated monthly, are prepared and sent to improvement teams. Because OPQC targets

prematurity primarily, improvements will have a significant effect on reducing the number of children with special healthcare needs. **SPS** will develop a database that will capture all serious safety events at all eight children's hospitals in Ohio. For **SPS**, the key outcome for the first three years will be reduction in SSEs. This will continue in years 4 and 5 and, additionally, we will see reductions in some or all of the additional serious harms (e.g., SSIs, catheter associated-blood stream infections, serious ADEs). Process measures for SSE reduction will be based on the common cause database. From the pilot site, we anticipate these will include percent reliability of universal protocol use in the operating room and for all invasive procedures and percent clinical staff trained in error prevention; additional process measures might include the percent reliability of the evidence-based care bundle. **OPQC** metrics will include outcome measures (e.g., percentage of late preterm scheduled deliveries in Ohio and rate of unit-acquired infections in hospitalized premature infants in Ohio) and process measures (the degree to which hospitals participate in OPQC, the ability to provide performance reports on state mandated measures to all maternity hospitals in Ohio). OPQC's current measures, which include 47% of all Ohio births and ~80% of all infants born less than 30 weeks gestational age, include all mothers and infants at OPQC sites with Medicaid/CHIP insurance. Because OPQC uses birth certificates for some measures, program effects are specific to those covered by Medicaid (CMS purpose 1). Similarly, OPQC has completed a study of costs avoided by prevention of NICU-associated infection. With CHIPRA funding, OPQC will expand in size, scope and sophistication to include all perinatal providers in Ohio. Because this collaborative is population-based and includes public and private payers and state government, systemic health delivery system improvements are anticipated and can likely be replicated nationally (as is currently occurring with OPQC strategies being utilized in MA, NC, TN, IL, and other states).

SECTION 2 - CATEGORY E: ENHANCING EPSDT AND THE DEVELOPMENTAL AND BEHAVIORAL HEALTH CARE SYSTEMS' DELIVERY, COORDINATION, QUALITY AND ACCESS

[Please note: References are listed on <http://www.odh.ohio.gov/landing/beacon/beacon.aspx>]

2. Mission, vision, and objectives and alignment with CMS Grant Category E goals

More than 1.1 million of Ohio's children on Medicaid are served through managed care plans (MCPs). For the first time, Ohio Medicaid and all the MCPs are engaged in a collaborative performance improvement project. This five-year, statewide collaborative performance improvement project began in February 2009 and is dedicated to improving access to EPSDT. (Other efforts underway in Ohio to improve EPSDT, including performance metrics, are described at <http://www/odh.ohio.gov/landing/beacon/beacon.aspx> .) This creates the perfect environment in which to develop a decision support network that links expertise in children's developmental and behavioral health with primary care clinicians and community providers who care for children on Medicaid. We will explore evidence-based practices for the framework of mental health and the continuum of developmental and behavioral health care, that emphasizes early identification and intervention, and strengthens and sustains the capacity of Ohio Medicaid to improve outcomes for children.

Mission: To achieve measurable improvements in outcomes for children on Medicaid/CHIP with developmental and behavioral health concerns by implementing the Ohio Pediatric/Psychiatry Decision Support Network (OPPDSN), a technologically supported system of consultation, support and communication that will 1) increase access to developmental and behavioral health and psychiatric consultation; and triage for person-centered medical homes, primary care, and community mental health provider organizations and 2) be informed by improvement science to achieve measurable results and improved outcomes for children on several metrics. **Vision:** Our vision is to measurably improve outcomes for children with special

health care needs in Ohio by implementing and integrating systems of care that support the appropriate identification, assessment, referral and treatment of children with or at risk for the continuum of developmental and behavioral health concerns. Our vision is that every child in Ohio identified as in need of intervention will obtain appropriate developmental and behavioral health evaluation and have access to the OPPDSN that links the child, the primary care medical home, and community health resources with developmental, behavioral and psychiatric expertise. This builds on the children’s hospital provider model described in Category C by including developmental behavioral pediatricians and child psychiatrists. Ohio is committed to using improvement science to: 1) develop a Decision Support Network that provides coordinated support to any primary care physician or other primary care provider, and involving developmental/behavioral and psychiatric clinicians. The goals are to 1) ensure appropriate use of atypical antipsychotics (AtAps) in children; 2) work with community behavioral health practitioners to build knowledge and expertise in preventing and addressing developmental and behavioral concerns, and 3) expand the current network of engaged primary care practices in Ohio, so they can implement the American Academy of Pediatrics (AAP) mental health competencies and other OPPDSN best practices. **Aims:** – The aims of the Ohio BEACON model align fully with the CMS Category E objectives.

Category E - SMART Aims	CMS Category E Objectives
<p>Aim 1 (Planning Phase) – To implement a coordinated decision support network that will improve care and outcomes for children with developmental and behavioral health concerns by September 31, 2012: (a) utilize an evidence-based process to design an initial quality improvement initiative involving all 8 children’s hospitals to ensure appropriate use of atypical antipsychotics (AtAps) in youth, (b) utilize an evidence-based process to identify and select diagnosis and treatment protocols that can be used statewide, and (c) develop a mechanism for ongoing engagement of the 60 primary care practices and >700</p>	<p>Objective 1: To demonstrate that this model of care to improve the quality of children’s health care, especially children with special health care needs, can be implemented</p> <p>Objective 2: To learn how best to implement this model of care, including the use of a collaborative framework of state agencies, providers, stakeholders,</p>

<p>primary care clinicians in a learning network that is integrated as part of OPPDSN. This will support primary care adoption of the American Academy of Pediatrics (AAP) mental health competencies and ensure increase in EPSDT screening rates.</p>	<p>payers, and parents, and identify barriers and how they can be overcome Objective 3: to determine the impact of this new model of care on children’s health care access and quality, especially children with special health care needs</p>
<p>Implementation Phase</p>	
<p>Aim 2 – Use improvement science methods and technologic support to implement a decision support network to improve care and outcomes for children by linking developmental and behavioral support among all 8 children’s hospitals, community developmental and behavioral practitioners, primary care clinicians and MCPs by December 31, 2014. We will: (a) <i>offer training and consultation to all primary care providers treating children and adolescents with behavioral health problems</i>, (b) initiate a collaborative approach to ensure the appropriate use of AtAps in 90% youth by December 2014, (c) integrate the engaged primary care teams into the decision support network so they may provide ongoing feedback and testing of the strategies and develop the AAP mental health competencies and other OPPDSN practices by December 2011, (d) engage the community mental health practitioners in additional training so that they can link with the network by December 2011, (e) involve child trauma and thought/mood disorder specialists in providing additional training by June 2013, and (f) utilize improvement science to provide ongoing feedback and evaluation of the network.</p>	<p>Objective 3: To determine the impact of this new model of care on children’s healthcare access and quality, especially children with special health care needs</p>
<p>Aim 3 – Adapt current efforts to ensure appropriate identification of children at risk or with the continuum of developmental and behavioral health concerns and improve the rates of young children on Medicaid in Ohio who have EPSDT visit claims for developmental screening to 85% (from current 13%) by December 31, 2014.</p>	<p>Objective 3: To determine the impact of this new model of care on children’s healthcare access and quality, especially children with special health care needs</p>
<p>Impact Assessment</p>	
<p>Aim 4 – Assess the impact on children’s health from various perspectives: stakeholders, practitioners, FQHCs, MCPs, network use and satisfaction metrics, and Medicaid claims data.</p>	<p>Objective 3: To determine the impact of this new model of care on children’s healthcare access and quality, especially children with special health care needs</p>

2. Strategies for Implementing the Ohio Pediatric/Psychiatric Decision Support Network

We will build on the engaged infrastructure of a statewide consortium to implement the

OPPDSN and address the need for enhanced diagnostic, evaluation and treatment capacity for children with the continuum of developmental and behavioral health concerns. The need for expertise exceeds current health system capacity in Ohio. In addition, community mental health and developmental disabilities systems often serve the same children, with coordination varying by county. Several states have implemented model systems that efficiently provide child psychiatry support for primary care clinicians, community developmental and behavioral health practitioners, children, and families to address difficult diagnostic and management issues. In Ohio, several children's hospitals provide this type of 24/7 consultation to local clinicians, but there is currently limited interaction *between* these sites and no widespread statewide safety-net available to every clinician. OPPDSN will include three tiers: 1) children's hospital developmental and behavioral health teams; 2) community/general psychiatry clinical and behavioral health teams; and 3) primary care clinical teams. There will be interactions within each group and across the tiers to ensure coordinated systems that best support the child and family. This will be an ongoing learning network (rather than a time-bounded learning collaborative) that encourages collaboration and joint problem-solving and accelerates improvement. **Design Phase (9 months):** An expert group (i.e., child psychiatrists, developmental/behavioral pediatricians, primary care clinicians, and experts in childhood trauma and mood/thought disorders) will: 1) design and develop the OPPDSN infrastructure, initially focusing on children's hospitals; 2) use a structured evidence-based process to review existing guidelines¹⁻⁴ and toolkits^{4, 5} to develop consistent protocols; and 3) use quality improvement methods to design an initial improvement project focused on the appropriate use of AtAps in children and youth. 2007 Ohio Medicaid claims data document the cost of AtAps at \$34 million for children between 0-18 years of age; varying by age, 4-6 % of boys on Medicaid, aged 6-18

years, received these medications at rates 2-3 times those of girls. With the expert group, we will develop guidelines for appropriate use of AtAps and specific metrics to track progress in order to assure appropriate use of AtAps in 90% of youth on Medicaid by December 2014. With the Ohio AAP, we will: 1) develop a structured mechanism for ongoing engagement of the 60+ practices and >700 clinicians who have participated in the developmental screening learning collaboratives over the last 18 months; and 2) build on the community collaborations developed through targeted outreach programs (see ADEPP below). These “on-the-ground” clinicians can provide feedback on the design of the improvement initiative and OPPDSN. The technologic infrastructure (e.g., video, telephone, secure e-visits and/or email) will be developed to support the provision of timely 1) diagnostic support, 2) management of a variety of disorders, especially medication management, care coordination and referral needs, and 3) web connection/linkage for materials, tools, guidelines, and physician and family educational materials. **Implementation Phase:** We will institute an improvement initiative focused on appropriate use of AtAps. As in Category C, this will utilize collaborative learning involving psychiatry teams from children’s hospitals and primary care and developmental/behavioral health teams in referral areas. Building on a network of strong local community connections is especially important in light of the enormous diversity of Ohio, ranging from several major urban areas to very remote areas of Appalachia. We will use a collaborative approach involving expert clinicians from around the state, content experts, regular data to track performance and provide feedback, and support to implement best practices. This will involve clinical team learning sessions, conference calls, webinars, site visits, and list serve communication, as well as engaging senior leadership. Training and support of these community practitioners, FQHCs and MCPs will be important in building statewide capacity. We will utilize curriculum training programs that support parents in

better “managing” children’s challenging behaviors. These activities will be coordinated with clinical and data work underway with OHP, Medicaid MCPs and stakeholders related to the pharmaceutical benefit. In Year 4, experts on childhood traumatic stress and additional thought and mood disorders will provide training. A key component of a successful OPPDSN will be the strong involvement of the primary care community. We will build on the interest and experience we have working with a *collaborative network of approximately 60 engaged primary care practices and >700 clinicians from throughout Ohio*, including 6 residency training programs affiliated with the children’s hospitals that participated in collaborative learning activities focused on the implementation of office systems for autism, developmental, and social-emotional screening. These practices are interested in remaining connected with the faculty and other participating practices. Ohio has demonstrated experience in providing training and support to primary care clinicians to implement developmental and behavioral health screening and has the tools to develop primary care office systems for behavioral health. We will leverage current Medtapp funds to create self-study online tools and link to Ohio AAP and OPPDSN websites; enabling primary care clinicians to learn how to identify children with developmental and behavioral concerns. BEACON will provide a menu of activities to support clinical teams in implementing systems for screening, referral, and coordination for children with developmental and behavioral concerns (e.g., self-study modules and technical assistance through a listserve, conference calls and webinars, with the opportunity to engage with developmental and behavioral health experts). This will support primary care clinicians’ adoption of the AAP mental health competencies⁶ and registries to monitor care plans for children identified as at-risk. Our work with managed care plans will ensure broad dissemination.

Risk status	Developmental and Behavioral/Emotional Interventions
Green No risk,	Anticipatory Guidance and Developmental Activities

low risk, and normal screens	If low risk, consider sooner than usual follow-up
Yellow = High risk or failed screen	Thorough developmental, behavioral, psychosocial history and exam, hearing and vision exams. Refer to HMG or schools for developmental/psychoeducational evaluation If behavioral problems are discreet and of less than 6 months duration, consider office-based intervention and community mental health resources for parenting training and support
Red = Abnormal evaluation	Pursue full medical diagnostic evaluation to establish cause of developmental delay or behavioral concern. If behavioral problems are broad or chronic and/or there is evidence of parental psychopathology, lack of partner support, poor coping, or anger management, then coordinate community linkages for intervention services, including Help-Me-Grow, family support services, and mental health services. Decision support from specialist or referral as needed. (OPPDSN)

The Category E project also includes robust integration with Category A (rates of social-emotional screening and follow-up for attention deficit hyperactivity disorder (ADHD) care and after mental health hospitalization) and Category B. The OPPDSN technological infrastructure will be enhanced by information stored in the central data repository (Category B). The data system will allow assessment of medication history, current pharmacotherapy and prescription refills, provide alerts for polypharmacy and low adherence, and use for quality improvement.

3. Expected stakeholder involvement in OPPDSN development and implementation

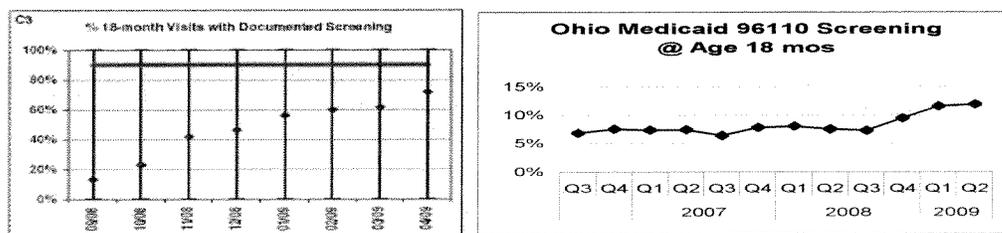
Ohio has had extremely strong and committed stakeholder involvement related to this work and will build on these collaborations. From 2004-2007, leading state officers, patient advocates, primary care clinicians, and mental health professional organizations participated in a task force convened by ODMH to address glaring insufficiencies in the access to psychiatric services for Ohio's children. Strong recommendations were made to enhance the quality of services delivered through primary care settings, especially for children enrolled in Medicaid in urban centers and rural areas. As a result, an expert advisory committee outlined the next steps, including OPPDSN components. Committee members include ODMH, the Ohio Department of Job and Family Services (ODJFS), the Ohio Children's Hospital Association, 8 regional health

care institutions, Ohio chapters of the American Academy of Child and Adolescent Psychiatry and the AAP, and family advocacy organizations. ODJFS, ODH, and Ohio AAP have partnered to develop programs to improve the identification, evaluation and treatment of children at risk for developmental, autism, and social-emotional delay. Ohio's selection in 2007 to participate in the National Academy for State Healthy Policy Assuring Better Health and Child Development Screening Academy and the Commonwealth Fund Improvement Partnership program accelerated state efforts to improve the delivery of early child development services for low-income children. The advisory committee established for these projects, involving members of parent groups, professional organizations, state agencies, academic centers/children's hospitals, *continues to meet monthly*. Due to Autism Task Force advocacy, the legislature awarded funding to ODH and Ohio AAP for the Autism and Developmental Education Pilot Project (ADEPP).

4. Ohio's Capacity to Implement and Sustain this Demonstration Project

Ohio is well-positioned to implement and sustain this project. Over the last several years, it has developed a results-oriented, measurement-based emphasis to its child health programs. We will build on the provider-based network model and developing quality infrastructure of the children's hospitals (Category C) and extend support to child psychiatry. In early 2008, the ADEPP project held 26 focus groups with 287 parents, medical professionals, direct service providers, and early care providers in five geographically diverse communities to gather perspectives on issues relating to the identification, evaluation, and treatment of children with developmental and behavioral health concerns. ADEPP then developed a public awareness campaign to promote the importance of addressing developmental concerns early, instituted community diagnostic partnerships that support primary care clinicians and families by expediting assessment of children identified through screening, and linked efforts with local and

state childcare agencies. In summer 2008, educational outreach strategies were implemented to specifically address low rates of physician screening: 1) highlighting information in Ohio AAP newsletters and listserves; 2) Grand Rounds at seven large medical centers; 3) an Ohio AAP-linked website (www.concernedaboutdevelopment.org) with information, guidelines, and tools that had 10,000 hits in 5 months; and 4) an 8-month pilot learning collaborative involving 21 primary care practices, including 6 residency training sites. It used improvement science methods to integrate screening into office routine, followed AAP recommendations for screening of young children, and provided American Board of Pediatrics maintenance of certification credit. Screening rates at recommended ages increased significantly for all practices, from 14% at baseline to 70% after the collaborative. The left graph shows aggregate data collected by practices for the 18-month developmental screening; the right graph shows preliminary analysis of Medicaid claims for developmental screening code 96-110 at the 18-month EPSDT visit.



This project linked primary care practices with community resources for referral, evaluation, and treatment. We developed, tested, and refined referral and feedback forms with the practices and the Ohio Early Intervention Program and held training sessions for practices and 16 counties in the pilot communities. In addition, ADEPP trained five community-based diagnostic partnership teams in the use of the standardized, comprehensive evaluation for children with language and social development concerns, including autism, and held four town hall meetings to engage the medical and early care communities in addressing shared concerns. These experiences will be used in the development of OPPDSN. Ohio will also be informed by a successful program to

improve care for children with ADHD⁷ and the 5-year Project LAUNCH Ohio,⁸ led by Integrating Professionals for Appalachian Children⁹ (see letter of support).

5. How the demonstration projects will answer National Evaluation questions

The purpose of Category E is to allow states to test promising solutions to address problems in health care coordination. CMS objectives include demonstrating that the model can be implemented, providing strategies for implementing the framework, and documenting its impact. As with Category C, BEACON Category E will utilize a multi-provider, cross-system, statewide network linked with hospital-based support systems and evidence-based improvement and reliability science methods. We will monitor participation in OPPDSN activities by the child psychiatrists, the community developmental and behavioral health and primary care clinicians and document effective strategies and barriers for network initiation and implementation. We will utilize specific measures of care processes and outcomes to drive improvement and determine program impact. For example, we will track provider practice on a series of process measures and child health outcomes through both practice-collected data and Medicaid claims (e.g., use of structured screening tools at EPSDT examinations, appropriate use of AtAps, and clinic follow-up after initiation of ADHD medication). Aggregate and confidential individual reports on improvement measures will be sent to participating teams monthly. Current efforts have demonstrated significant improvements in use of structured screening in target primary care practices, with impact on statewide rates (Medicaid claims). The grant will provide essential support to use quality improvement science along with our collaborative efforts. We look forward to working with CMS as we implement the OPPDSN, and view this as an opportunity to bring new energy to our efforts to improve outcomes for children.

SECTION 3: DRAFT OPERATIONAL PLAN/PROCESS FOR THE DEVELOPMENT OF FINAL OPERATIONAL PLAN

The Ohio **B**est **E**vidence for **A**dvancing **C**hildhealth in **O**hio **N**OW (**BEACON**) initiative will demonstrate how to produce marked improvement in the quality of health care and outcomes for its children enrolled in Medicaid – with the goal of achieving best-in-nation status for major child health quality indicators (<http://www.odh.ohio.gov/landing/beacon/beacon.aspx>). The BEACON Council will oversee all aspects of the development, implementation and evaluation of this initiative and is co-chaired by the Medical Director of Medicaid, Mary Applegate, MD, in ODJFS and the Director of ODH, Alvin Jackson, MD. The Council includes the heads of key Ohio government agencies; leaders in child health research, clinical practice, quality improvement (QI), and policy; state professional organizations representing child health delivery systems; business and insurer representatives; advocacy groups; and the community.

A full description of the BEACON council and its committees appears at:

<http://www.odh.ohio.gov/landing/beacon/beacon.aspx>

<p>Category A - Experiment with and Evaluate Use of Newly Developed and Evidence-based Measures of the Quality of Children’s Healthcare (<i>BEACON Quality Measurement Committee</i> linked to Category A)</p>	
<p>Task Owners:</p> <ul style="list-style-type: none"> • Leona Cuttler, MD -William T. Dahms Professor of Pediatrics, Professor of Bioethics, Director of the Center for Child Health and Policy, and Chief of Pediatric Endocrinology, Diabetes, and Metabolism at Rainbow Babies and Children’s Hospital, Case Western Reserve University, Cleveland; • Gerry Fairbrother, PhD -Professor of Pediatrics and Associate Director of the Child Policy Research Center at CCHMC; and • Lisa Simpson, MB, BCh, MPH - Director of the Child Policy Research Center, CCHMC,, Professor of Pediatrics, the University of Cincinnati, former Deputy Director, Agency for Healthcare Research and Quality (AHRQ) and member, AHRQ Subcommittee on Children’s Healthcare Quality Measures for Medicaid and CHIP Programs. 	
<p>Management Plan</p>	<p>The project will be managed through a committee, with representation from the research team, ODJFS, managed care plans, provider groups, consumers, and other stakeholders. The Category A Committee will be a subcommittee of the BEACON Council and will work through the Council</p>

	to accomplish goals. The committee will receive the annual reports on data quality and will meet to discuss improvement of reporting, inform the final design of the state evaluation plan, as well as give strategic advice and help guide accomplishment of project aims.
Implementation Activities	
3.1.10-12.01.10 Planning	<u>Developing a plan:</u> 1) for Ohio to report on core measures, assess barriers in data collection and identify ways to overcome them; 2) for core measure distribution/dissemination so they can be maximally effective in improving quality and integration with other grant categories; and 3) that provides an operational workplan for the BEACON Council, which will also be submitted to CMS with other Categories plans of the project.
12.01.10-07.01.13 Implementation	Build Ohio's capacity to improve the scope and impact of its quality performance monitoring and reporting system by July 2013. Activities include 1) assessing the information knowledge, needs, and preferences of parents, especially from vulnerable populations, for quality information; 2) assessing the information needs, preferences, prior exposure, use, barriers and concerns of stakeholders for quality information; and 3) producing a report recommending reporting format and distribution strategies for the core quality measures.
07.01.13-07.01.14 Implementation	Ohio will demonstrate the ability to collect and report on the full core set of child health quality measures identified by AHRQ/CMS using the required CMS format by July 2014. Activities include 1) producing a report on the full core set of child quality measures on Ohio's Medicaid population by July 2014 and 2) disseminating the final report broadly across Ohio.
Monitoring	The report recommending reporting format and distribution strategies for the core quality measures will be completed by July 2013. The report on the full core set of child quality measures on Ohio's Medicaid population will be completed by July 2014. The impact assessment will be completed by June 2015.
Category B - Promote the Use of Health Information Technology in Children's Health Care Delivery. (<i>BEACON Health Information Technology and Data Committee</i> linked to Category B)	
Task Owners:	
<ul style="list-style-type: none"> • Jon Barley, PhD, Chief, Bureau of Health Services Research, Information Technology, ODJFS, Office of Health Plans; • Lorin Ranbom is Director of the Ohio College of Medicine Government Resource Center, Ohio State University, and former Asst Deputy Director, Ohio Medicaid program where he successfully led the design and implementation of the Ohio Medicaid Data Warehouse and Decision Support System; and • Kelly Kelleher, MD, MPH is Professor of Pediatrics and Public Health and the ADS/Chlapaty Endowed Chair for Innovation in Pediatric Practice at The Ohio State University, Columbus, Ohio, VP for Community Health and Research Services, Nationwide Children's Hospital, Columbus. 	
Management Plan	The BEACON Health Information Technology and Data Committee will provide the leadership for the data repository and help to ensure the

	<p>scientific integrity of the project, while conforming to the ethics and standards of practice articulated by the American College of Epidemiology. The Task Managers (committee co-chairs) assume overall technical responsibility for the management of this project. The committee includes one representative from each primary data collection site. The committee reviews and makes recommendations to the Task Managers about the technical aspects of the repository. The committee reviews data collection practices and procedures to identify deficiencies and will address emerging issues that impact the data repository and may recommend changes to the BEACON Council.</p>
Implementation Activities	
3.1.10-12.01.10 Planning	<p><u>Developing a plan</u>: undertake a comprehensive planning process to develop the design specifications for the repository, including: 1) a complete data model (identifying fact and dimension tables from each of the data sources, and specifying data elements within the tables) for each project; 2) specifications for a) hardware, systems architecture and software, b) back-up and recovery, and information security; and c) specifications for Extraction/Transformation/Load (ETL) data processes and any interfaces, web data collection, web services, data reporting and OLAP tools. The committee will identify and use a process to select the participating host institution(s) for the central repository, will complete data governance and publication agreements for all BEACON Council committees and projects, and develop a communication infrastructure.</p>
12.01.10-12.31.11 Implementation	<p>Implement an integrated central data repository combining information from multiple sources: 1) revise existing Ohio Perinatal Quality Collaborative warehouse to include multiple quality projects and integrate into central data repository; 2) create interface, conversion, or necessary application programs, screens, and reports; 3) integrate Medicaid files into repository; 4) test ETL processes with source data, including Medicaid and vital statistics; 5) initiate load of historical data and initiate periodic loading cycle; 6) complete unit, system, and stress testing; 7) validate and test the system by business users; and 8) conduct user training, system conversion and deployment in a production environment.</p>
01.01.12-03.01.15 Implementation	<p>Utilize data system and data repository to provide comprehensive analysis and reporting to QI teams and collaboratives.</p>
Monitoring	<p>The impact of HIT services will be evaluated by 1) examining data quality and flow; 2) conducting an annual user satisfaction survey with each Committee to assess use and intended future use of BEACON HIT services; and 3) monitoring and evaluating use of reporting tools by members of the various learning networks. We will also assess the impact of the technologic aspects of the Ohio Pediatric/Psychiatry Decision Support Network interventions on children's health from various perspectives: stakeholders, practitioners, network use and satisfaction metrics, and Medicaid claims data.</p>
Category C - Evaluate Provider-Based Models that improve the Delivery of Children's	

Health Care. (<i>BEACON Project Committees for OPQC and SPS</i> linked to Category C)	
Task Owners:	
<ul style="list-style-type: none"> • Edward Donovan, MD, is a neonatologist, Professor of Clinical Pediatrics at the University of Cincinnati, a faculty member of the Child Policy Research Center at Cincinnati Children’s Hospital Medical Center, and Principal Investigator and Co-Chair, Executive Committee, Ohio Perinatal Quality Collaborative; • Karen Hughes, ODH Title V Maternal and Child Health Director; Supervisor for the WIC Supplemental Nutrition program. She leads Ohio's interagency workgroup on children's health. • Anne Lyren, M.D., Medical Director of Quality & Ethics and Interim Co-Chair of the Dept. of Pediatrics, Rainbow Babies & Children’s Hospital. Case Western Reserve Univ. She is a physician lead for SPS; and • Stephen E. Muething, MD is the Patient Safety Officer and Assistant VP for Patient Safety, Cincinnati Children's Hospital Medical Center, Associate Professor of Pediatrics, University of Cincinnati; and lead of Cincinnati Children’s team that participated in the AHRQ Safety Reliability Network; he serves as SPS Improvement Advisor. 	
Management Plan	<p>Ohio Perinatal Quality Collaborative (OPQC) is led by its Project Committee, chaired by its two clinical leads, Drs. Ed Donovan (neonatology) and Jay Iams (maternal fetal medicine). The committee represents key clinicians, the OAAP and American College of Obstetrics and Gynecology, ODH, ODJFS and CCHMC. Day-to-day OPQC operations are managed by OPQC’s Program Director, Barbara Rose (mother of 18-year-old 27-week triplets), who is an experienced and capable manager. The committee serves as OPQC’s chief decision-making entity and meets monthly by phone.</p> <p>Solutions for Patient Safety (SPS) is led by its BEACON project committee consisting of representatives from the Ohio Children’s Hospital Association (OCHA) and improvement leaders from the participating hospitals. The committee meets by phone each month and in person each quarter. In addition to reporting to the BEACON council through its committee chairs/task managers, it reports to an executive steering team consisting of CEOs of the participating hospitals. SPS leaders also work closely with the OBRT.</p>
Implementation Activities	
3.1.10-12.01.10 Planning	<p><u>Developing a plan:</u></p> <p>OPQC – 1) engage senior leadership; 2) plan and begin development of a significantly enhanced OPQC data management infrastructure to support statewide improvement targeting population health (see Category B) and QI infrastructure that includes all 127 Ohio maternity and children’s hospitals; 3) provide input on curriculum for statewide Improvement Advisor Training that will be undertaken in collaboration with OCHA as part of SPS and Category E; and 4) develop outreach and recruitment plan to involve remaining maternity hospitals and NICUs, special care and well-baby nurseries as OPQC participants.</p> <p>SPS – 1) build will for transformation through leadership meetings with CEOs, legal departments and boards of trustees of all eight Ohio children’s</p>

	<p>hospitals; 2) conduct a diagnostic assessment with review of 2 years of previous serious safety events (SSEs) at the hospitals to create a common cause database, interview stakeholders at each site and assess safety culture; and 3) form a patient safety organization with site action plans.</p>
<p>12.01.10-03.01.13 Implementation</p>	<p>OPQC- 1) begin stepwise recruitment of remaining maternity hospitals and NICUs, special care and well baby nurseries; 2) in 2011, in collaboration with ODH, provide automated, monthly control charts to all 121 Ohio maternity hospitals on state-mandated perinatal performance metrics (use of antenatal steroids, maternal transfer of women expected to deliver prior to 32 weeks and cesarean sections in first birth, low risk women); 3) disseminate proven-successful strategies to reduce unnecessary elective deliveries and neonatal intensive care unit (NICU)-associated infections and scheduled deliveries; provide support to new hospitals to implement successful improvement strategies; 4) develop subpopulation-specific analyses that address the reduction of disparities in pregnancy outcomes in Ohio; 5) in 2012, provide disparity-specific care and outcome reports with segmentation by payer, race/ethnicity and selected demographic characteristics reports to all participating OPQC sites. Use these reports to involve all participating sites in selection of next improvement topics.</p> <p>SPS – 1) undertake interventions to reduce serious harm based on preliminary results and diagnostic assessment; 2) disseminate proven strategies and individualize support to sites; 3) serious safety event reduction experts will provide individual consultation to each site; 4) develop a safety coach program at each site and identify best practices for simulation training; 5) working with senior executive and legal representatives, identify best practices for safety governance and transparency.</p> <p>Both projects will use an improvement framework that includes shared data (see Category B above), learning collaboratives, and feedback. In addition, both projects will utilize hospital-based Improvement Advisors to support local improvement efforts with specific project oversight from OPQC and SPS Improvement faculty and staff.</p>
<p>03.01.13-03.01.15 Implementation</p>	<p>OPQC – Implement and test systems to achieve and maintain improvement in rates of unnecessary elective deliveries and NICU-associated infections across all participating OPQC sites (new and established). Develop subpopulation-specific analyses and interventions to reduce disparities in pregnancy outcomes across Ohio and design and implement interventions that target identified disparities. Select and plan new clinical topics for improvement.</p> <p>SPS – Based on the common cause database and expansion of data collection to include all SSEs, implement and sustain successful strategies to reduce specific serious adverse events (AE) at individual hospitals across the entire eight-hospital system. Continue efforts to focus on developing and implementing highly reliable situation awareness strategies at all hospitals, such as daily huddles and walk rounds to identify</p>

	potentially high-risk behaviors and trouble spots. Both projects will continue to focus on developing improvement capability.
Monitoring	The SPS and OPQC learning networks utilize similar improvement methods that include face-to-face learning sessions, monthly conference calls and discussion by listserv, and regular data feedback. SPS also undertakes regular site visits, individual calls with hospital team leaders, and milestone review sessions. For all SPS and OPQC projects, measures, monthly, both quality of patient care and patient health outcomes. Hospital-specific, confidential reports, updated monthly, are prepared and sent to improvement teams during the month following the month that the relevant care was provided. OPQC will use control charts to monitor changes in elective deliveries and NICU-associated infections. SPS will track changes in serious safety events on run charts showing events per 10,000 adjusted patients days and days between events.
Category E – Enhancing EPSDT and the Developmental and Behavioral Health Care Systems’ Delivery, Coordination, Quality and Access (<i>BEACON Project Committee</i> linked to Category C)	
Task Owners:	
<ul style="list-style-type: none"> • John Duby, MD, FAAP, is Director, Division of Developmental and Behavioral Pediatrics; Co-Director, NeuroDevelopmental Center, Akron Children’s Hospital; Medical Director, Family Child Learning Center, Tallmadge, Ohio; President, Ohio AAP Foundation; and Medical Director of the Autism Diagnosis Education Pilot Project (Ohio Chapter of the AAP); • Carole Lannon, MD MPH is Co-Director, Center for Health Care Quality, Cincinnati Children’s Hospital; PI, AHRQ Center for Education and Research in Therapeutics; Professor Pediatrics, University of Cincinnati; Drs. Duby and Lannon co-lead Ohio Concerned About Development collaborative; and • Marion Sherman, MD, is Medical Director, Ohio Department of Mental Health; a child and forensic psychiatrist, former president of the Ohio Psychiatric Physicians’ Association, former NAMI Ohio Psychiatrist of the Year, and was formerly the Chief Clinical Officer at the Twin Valley Psychiatric Hospital in Columbus. 	
Management Plan	The BEACON project committee will include individuals from two existing groups: 1) an expert advisory committee that has been meeting during 2009 to develop the Ohio Pediatric/Psychiatry Decision Support Network, consisting of the ODJFS, OCHA (8 regional healthcare institutions), Ohio chapters of the American Academy of Child and Adolescent Psychiatry and the AAP, and parent advocacy organizations and 2) the Leadership Group of the Ohio project funded by technical assistance from the NASHP Assuring Better Child Development and consists of representatives from ODJFS, ODH, parent advocacy organizations, the Ohio chapters of the AAP and the American Academy of Family Physicians, developmental behavioral pediatrician experts, and QI experts.
Implementation Activities	
3.1.10-12.01.10	Planning for the design, development, and implementation of a

Planning	coordinated network, including a technologically supported decision support network that will improve care and outcomes for children with the continuum of developmental behavioral disorders. Activities include: 1) using an evidence-based process to design an initial QI initiative to ensure appropriate use of atypical antipsychotics in youth by both behavioral health and primary care professionals; 2) using an evidence-based process to identify and select diagnosis and treatment protocols that can be used statewide; and 3) working with colleagues on Category B to plan the implementation of a technologically supported decision support network based in the children’s hospitals; and available to all primary care providers to assist in keeping children in their medical homes, while improving the quality of care, and 4) developing a mechanism for ongoing engagement of the >700 clinicians in a learning network that will a) integrate with the decision support platform involving child mental health professionals, b) support the adoption of the AAP mental health competencies and other OPPDSN best practices (“Competencies”) by all primary care clinicians in Ohio, and c) adapt lessons to provide ongoing technical assistance for the use of screening to identify children with developmental/behavioral issues at all EPSDT visits.
12.01.10-03.01.12 Implementation	Implement a network to improve care and outcomes for children with the continuum of developmental behavioral disorders, <i>by Sept. 31, 2012</i> by linking developmental, behavioral health and psychiatric support among the eight Ohio children’s hospitals, community behavioral health and mental health practitioners, and primary care clinicians. Activities include: 1) an initial collaborative focused on ensuring the appropriate use of atypical antipsychotics in youth and that involves child psychiatry teams from eight children’s hospital sites by June 2011; 2) integrating the engaged cohort of primary care teams into the decision support network so they may develop the “Competencies” (noted above) and provide ongoing feedback and testing of proposed strategies by Dec. 2011; 3) developing and engaging the community mental health practitioners in additional training so that they can link with the network by Dec. 2011; 4) continued support and technical assistance to all primary care clinicians to maintain and increase the use of screening at all EPSDT visits to identify children with developmental and behavioral issues; and 5) using improvement science to provide ongoing feedback and evaluation of the network.
03.01.12-12.31.14	Strengthen the infrastructure of a network to improve care and outcomes for children with the continuum of developmental and behavioral health disorders, including a decision support network, <i>by Sept. 30, 2012</i> by linking developmental, behavioral health and psychiatric support among the Ohio children’s hospitals, community behavioral and mental health practice. Activities include: 1) additional improvement initiatives on key clinical topics, including additional training that involves child trauma specialists on additional clinical topics by Jun. 2013; 2) integrating

	primary care teams into the decision support network so they may develop the “Competencies” (noted above) and provide ongoing feedback and testing of proposed strategies; 3) integrating the community mental health practitioners in additional training so that they can link with the decision support network (OPPDSN); 4) ongoing educational and technical assistance for primary care clinicians on the use of structured screening at all EPSDT visits to identify children with the continuum of developmental behavioral issues; and 5) use improvement science to provide ongoing feedback and evaluation of the network.
Monitoring	The learning networks in Category E will utilize collaborative quality improvement methods and will include face-to-face learning sessions, monthly conference calls and discussion by list-serve, and regular data feedback. In addition, regular site visits, conference calls with senior leaders, and milestone review sessions, and individual calls with team leaders are conducted.

Each task leader is skilled at collaboration and experienced with the design, development, and implementation of large multisite projects. Each Category and project has a well-defined plan for initial operations. The BEACON Council, with primary support from the Task Leaders of each category, will have lead responsibility for developing the final Operational Plan. During the first nine months of the grant (Planning Phase), the Council will meet monthly to develop the final Operational Plan in conjunction with its Committees and in consultation with CMS. During the subsequent Implementation Phase of the final Operational Plan, the Council will meet quarterly until the last six months, at which time monthly meetings will resume as full analyses and reports are prepared. Additional interactions by conference call, webinar, and listserv will occur as needed. At each Council meeting, the Chairs will report on overall progress and raise issues for discussion that relate to organization and planning or implementation of the initiative. The chair(s) of each Infrastructure Committee and the Chair(s) of each Project Committee will report on progress, accomplishments, and barriers/challenges. While it is expected that decision making will continue to be consensus based as it has been to date, we expect that there may be times when consensus is not possible. In such instances, decisions of the Council will be by

majority vote, recognizing that if the issue is one involving state policy or resources, then the decision is advisory only to the respective state agency. ODJFS will have final decision making, as they are the lead contract agency for the grant. This proposal involves extremely strong stakeholder support and commitment – with a broad partnership of public and private sector actors operationalized through the BEACON Council, including key state agencies addressing child health, advocacy groups, professional organizations representing child health providers, children’s hospitals, academic institutions and researchers, and other non-governmental organizations. The improvement initiatives offer additional opportunities for stakeholder and public input; additional stakeholder and public input will be sought as indicated.

3. Monitoring: Each project will utilize strong project management to ensure work is timely and on track. In addition, each collaborative improvement network (i.e., OPQC, SPS, and the Category E efforts) will utilize face-to-face learning sessions, monthly conference calls, site visits, individual calls with team leaders, and milestone review sessions to monitor participant feedback. Ohio’s successful experience with monitoring the OPQC deliverables as part of Ohio’s CMS Neonatal Transformation Grant attests to its ability to meet obligations in monitoring CHIPRA grant deliverables. Time-specific deliverables drive OPQC’s operations and its budget; Ohio will utilize this same approach with all the BEACON CHIPRA projects.

4. Data Collection: As demonstrated by Ohio’s performance with the CMS Neonatal Transformation Grant, Ohio intends to be fully cooperative with the National Evaluation Plan. Ohio deliverables as part of CHIPRA will include National Evaluation measures given equal value to operational, care process and clinical outcome measures.

Independent Evaluation Plan: The proposed approach to Category A includes a mixed methods evaluation to assess the use and impact of the quality measures and reports. Categories C and E

will be run as improvement projects in which data collection is an integral part of the initiative. We will endeavor to use population-based datasets whenever possible (e.g., birth certificate data, Medicaid claims data). Examples of previous data utilized by projects are on the website. For all CHIPRA aims, the BEACON projects will use improvement methods and care process and clinical outcome measures to evaluate progress – independent of the National Evaluation measures. This is currently done for the OPQC, SPS, and Concerned About Development initiative (CADLC). Each performance measure, as an aggregate of all BEACON collaborative improvement participants, will be posted monthly on the project web site (for OPQC, this is a public website). Each participant will receive its site's own set of measures, updated monthly, via the proposed BEACON password-protected extranet (this is currently done with OPQC, SPS, and CADLC).



Department of
Job and Family Services

Ted Strickland, Governor
Douglas E. Lumpkin, Director

Mr. David Greenberg
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

January 4, 2010

Dear Mr. Greenberg:

As Ohio's State Medicaid Director, it is my pleasure to submit our Ohio Medicaid proposal in response to the U.S. Department of Health and Human Services request for applications regarding the CHIPRA Quality Demonstration Grants. Our Medicaid program serves 1.1 million children and adolescents. We have assembled an exceptional group of highly experienced, skilled and passionate healthcare providers, professionals and children's advocates to test, evaluate and innovate through improvement science the achievement of quality improvement addressing a number of children's health issues and conditions.

The title of Ohio's proposal is **BEACON...Best Evidence for Advancing Childhealth in Ohio NOW.**

The State of Ohio has an excellent history of working in collaboration with our healthcare partners. The group we have assembled has been working in partnership the past several years to achieve measurable improvements in children's health as noted in our proposal and we will enhance our collaboration through the BEACON Council that has been created to guide this effort.

While Ohio's proposal is not a multi-state initiative, we believe that the size, number of significant urban areas and vast rural, Appalachia area provides the full scope of economic, social and ethnic diversity needed to test and evaluate quality improvement methods and outcomes. Our proposal will be instructive and replicable in other areas of the country.

We have 44 letters of support from a wide array of Ohio health and children's related organizations. These letters are from physicians, health professional organizations, hospitals, behavioral health and other providers. We also have letters from nationally recognized health quality improvement experts such as Donald Berwick, Institute for Healthcare Improvement, the American Academy of Pediatrics and The American Board of Pediatrics; as well as representatives of consumers and families such as NAMI, Voices for Ohio's Children and other recognized children's leadership.

I am available to answer any questions you may have and thank you for considering our proposal.

Sincerely,

Tracy Plouck
State Medicaid Director

30 East Broad Street
Columbus, Ohio 43215
jfs.ohio.gov

ATTACHMENT 2

Prohibited Uses of Grant Funds

1. To match any other Federal funds.
2. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
3. To provide infrastructure for which Federal Medicaid matching funds are available at the 90 / 10 matching rate, such as certain information systems projects.
4. To supplant existing State, local, or private funding of infrastructure or services, such as staff salaries, etc..

CHIPRA QUALITY GRANT APPLICATION CHECK-OFF COVER SHEET

Identifying Information

DUNS #: 809376072

State Agency: Ohio Department of Job and Family Services

Primary Contact Person: Maureen Corcoran, Ohio Department of Job & Family Services, OHP
Medicaid

Grant Category(s) (check all Grant Category(s) included in application)

- ✓ A-Quality Measures
- ✓ B-Health Information Technology
- ✓ C- Provider-Based Models
- D- Electronic Health Record Format
- ✓ E-Other-please designate major focus

Inclusion of the following for States' Grant Program and for specific Grant Category(s) in application

- ✓ Quality System Assessment
- ✓ Description of Grant Categories, Objectives, and Expected Outcomes
- ✓ Draft Preliminary Operational Plan
- ✓ Preliminary Budget

Acronyms Used in Ohio's BEACON Proposal

<p>AAFP - American Academy of Family Physicians</p> <p>AAP - American Academy of Pediatrics</p> <p>ABCD - Assuring Better Child Development</p> <p>ACOG - American College of Obstetricians and Gynecologists</p> <p>ADE - Adverse Drug Event</p> <p>ADEPP - Autism and Developmental Education Pilot Project</p> <p>ADHD - attention deficit/hyperactivity disorder</p> <p>AHRQ - Agency for Healthcare Research and Quality</p> <p>ARRA - American Recovery and Reinvestment Act</p> <p>AtAps - atypical antipsychotics</p> <p>BEACON - Best Evidence for Advancing Childhealth in Ohio NOW</p> <p>BMI - body mass index</p> <p>CAHPS - Consumer Assessment of Healthcare Providers and Systems</p> <p>CCHMC - Cincinnati Children's Hospital Medical Center</p> <p>CHIP - Children's Health Insurance Program</p> <p>CHIPRA - Children's Health Insurance Program Reauthorization Act of 2009</p> <p>CMS - Centers for Medicare and Medicaid Services</p> <p>EDC - Electronic Data Capture</p> <p>EPSDT - Early Periodic Screening, Diagnosis, and Treatment</p> <p>FFS - fee-for-service</p> <p>FQHC - Federally Qualified Health Centers</p> <p>HEDIS - Healthcare Effectiveness Data and Information Set</p> <p>HMG - Help Me Grow</p> <p>HIT - Health information technology</p> <p>IHI - Institute for Healthcare Improvement</p> <p>IRB - Institutional Review Board</p> <p>LAUNCH - Linking Actions for Unmet Needs in Children's Health</p> <p>MCP - managed care plan</p>	<p>MITA - Medicaid Information Technology Infrastructure</p> <p>MITS - Medicaid Information Technology System</p> <p>MMIS - Medicaid Management Information Systems</p> <p>NAMI - National Alliance on Mental Illness</p> <p>NASHP - National Academy of State Health Policy</p> <p>NCQA - National Committee for Quality Assurance</p> <p>NICU - neonatal intensive care unit</p> <p>NIH - National Institutes of Health</p> <p>OBRT - Ohio Business Roundtable</p> <p>OCHA - Ohio Children's Hospital Association</p> <p>ODH - Ohio Department of Health</p> <p>ODJFS - Ohio Department of Job and Family Services</p> <p>ODMH - Ohio Department of Mental Health</p> <p>OPPDSN - Ohio Pediatric/Psychiatry Decision Support Network</p> <p>OPQC - Ohio Perinatal Quality Collaborative</p> <p>PICU - pediatric intensive care unit</p> <p>PSO - patient safety organization</p> <p>QI - quality improvement</p> <p>RB&CH - Rainbow Babies & Children's Hospital</p> <p>RFP - request for proposals</p> <p>SCHIP - State Children's Health Insurance Program</p> <p>SSE - Serious Safety Event</p> <p>SPS - Solutions for Patient Safety</p> <p>SQL - Structured Query Language</p>
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**Participants in Ohio CHIPRA BEACON Proposal
January 7, 2010**

Below is a list of individuals who have been active in preparing this grant application, including many of the individuals/organizations who will serve on the BEACON Council.

The following three pages contain biographical sketches for each of these individuals.

Co-Chairs Ohio BEACON Council & Support

Alvin Jackson, MD
Mary Applegate, MD
Melissa Bacon
Harvey Doremus
Maureen Corcoran

Developmental/Behavioral Health Leadership

John Duby, MD
Marian Sherman, MD
Mike Schroeder
Kay Rietz
John Campo
Melissa Arnold

Quality Improvement Capacity

Carole Lannon, MD
Uma Kotagal, MD
Nick Lashutka

Community Advisory Assistance

Gayle Channing Tenenbaum
Mary Wachtel

Health Information Technology Leadership

Lorin Ranbom
Kelly Kelleher, MD
Jon Barley, PhD

Quality Measurement Leadership

Leona Cutler, MD
Lisa Simpson, MD
Gerry Fairbrother, PhD
Deborah Saxe
Dan Hecht

Providers Based Models: Hospital Safety & Perinatal Quality

Ed Donovan, MD
Karen Hughes
Anne Lyren, MD
Stephen Muething, MD
Nick Lashutka
Uma Kotagal, MD
Mike Bird, MD
Jay Iams, MD

Biographical Summaries – Ohio CHIPRA BEACON Proposal

Co-Chairs, Ohio BEACON Council:

Mary Applegate, MD, Medical Director for Ohio Medicaid program, 2006 to Present.

Dr. Applegate provides clinical and quality leadership for the Ohio Medicaid program. She is double-boarded in Internal Medicine and Pediatrics and is a fellow of the American Academy of Pediatrics and the American College of Physicians. She maintains a private practice in rural Ohio and teaches Medical students and residents at the OSU College of Medicine.

Alvin D. Jackson, MD, Director, Ohio Department of Health, June 2007 to Present.

As Ohio Health Director, Dr. Jackson has sought to make affordable, quality health care accessible to all Ohioans regardless of their personal situation. Before his state service, he practiced 12 years as Medical Director at Community Health Services, a Rural Health Center in Fremont, Ohio providing primary care to rural Ohioans and migrant workers.

Other BEACON Leaders, Supporters and Advisors:

Melissa Arnold, Executive Director, Ohio Chapter of American Academy of Pediatrics

Melissa Bacon, Director, Public Policy and Advocacy, Ohio Children's Hospital Association

Jon Barley, PhD, Chief, Bureau of Health Services Research, Ohio Department of Job and Family Services, Office of Ohio Health Plans. Dr. Barley is the health information technology lead for Ohio Medicaid including budget and payment analysis; Medicaid quality strategy and program development through partnerships with academic researchers. He previously led Ohio's Medicaid managed care program serving 1.4 million members.

Mike Bird, MD, Vice President for Medical Affairs, Akron Children's Hospital

John Campo, MD, Nationwide Children's Hospital and The Ohio State University Hospital.

Dr Campo is a psychiatrist specializing in child and adolescent psychiatry

Maureen M. Corcoran, MSN, MBA, Assistant Deputy Director for Policy and Programs, Ohio Department of Job and Family Services, Office of Ohio Health Plan (Ohio Medicaid.) Ms.

Corcoran supervises Ohio Medicaid program functions including: Medicaid eligibility; managed care; long term care; home and community based waivers; benefit design and health plan policy.

Leona Cuttler, MD, Professor of Pediatrics, Rainbow Babies and Children's Hospital, Case Western Reserve University, Cleveland, Ohio. Dr. Cuttler is a Professor of Bioethics, Director of the Center for Child Health and Policy, and Chief of Pediatric Endocrinology, Diabetes, and Metabolism. Her research interests include childhood growth disorders, diabetes, and obesity.

Edward F. Donovan, MD, Professor of Clinical Pediatrics, University of Cincinnati College of Medicine. Dr Donovan is on faculty at the Child Policy Research Center of Cincinnati Children's Hospital Medical Center and directs the Evidence-Based Decision Making program at

Cincinnati Children's. Dr. Donovan is the Principal Investigator of the Ohio Perinatal Quality Collaborative.

Harvey D. Doremus, MA, Senior Strategic Policy Advisor, Ohio Department of Job and Family Services, Office of Ohio Health Plans). Mr. Doremus leads children's healthcare quality improvement and serves on external committees addressing children's issues.

John C. DUBY, MD, FAAP, Director, Division of Developmental and Behavioral Pediatrics and Co-Director of the NeuroDevelopmental Center, Akron Children's Hospital. Dr. DUBY is Medical Director of the Family Child Learning Center, Tallmadge, Ohio, and Medical Director of the Autism Diagnosis Education Pilot Project sponsored by the Ohio Chapter of AAP.

Gerry Fairbrother, PhD, Associate Director, Child Policy Research Center, Cincinnati Children's Hospital. Dr. Fairbrother's research focuses on health care quality, using information technology for quality improvement, and removing barriers to health care access. Dr. Fairbrother holds a Ph.D. from The Johns Hopkins University.

Daniel Hecht, MPA, PhD/ABD, Health Services Research Supervisor, Ohio Department of Job and Family Services, Office of Ohio Health Plans, Mr. Hecht has 12 years experience working with Medicaid research including budgeting and rate setting. He led the team managing Ohio's Pay-for-Performance Purchasing Institute with the Center for Health Care Strategies.

Karen F. Hughes, MPH, Chief, Division of Family and Community Health Services, Ohio Department of Health. Ms. Hughes manages Ohio health programs including: the federal Maternal and Child Health block grant; the Women, Infants and Children Supplemental Nutrition program; Primary and Rural Health Care; Ryan White AIDS; and Part C Early Intervention federal grants. She leads Ohio's interagency workgroup on children's health.

Jay Iams, MD, The Ohio State University Medical Center and the James Cancer Hospital. Dr Iams is a nationally recognized expert in the field of maternal fetal medicine.

Kelly J. Kelleher, MD, MPH, Professor of Pediatrics and Public Health and ADS/Chlapaty Endowed Chair for Innovation in Pediatric Practice, The Ohio State University. Dr. Kelleher is Vice President for Community Health and Research Services at Nationwide Children's Hospital in Columbus. He is researching the relationship between antidepressant use and suicide/suicidality, and geographic prescribing patterns of psychotropic medications.

Uma Raman Kotagal, MBBS, MSC, Senior Vice President for Quality and Transformation, Cincinnati Children's Hospital Medical Center. Dr. Kotagal is managing the transformation of the Cincinnati Children's Hospital delivery system. She directs of the Center of Health Policy and Clinical Effectiveness and is a Professor of Pediatrics, Obstetrics and Gynecology at the University of Cincinnati. She has pioneered applying industrial science in health care quality.

Nicholas C. Lashutka, President, Ohio Children's Hospital Association). Mr. Lashutka represent the interests of Ohio's world class Children's Hospitals with legislative and executive

branches of government at the state and federal levels. Mr. Lashutka is past Director of Government Relations for the Ohio Business Roundtable.

Carole Lannon, MD, MPH, Co Director, Center for Health Care Quality, Cincinnati Children's Hospital Medical Center

Anne Lyren, MD, MSc, Medical Director of Quality & Ethics, Rainbow Babies & Children's Hospital. Dr. Lyren is a pediatric hospitalist at Rainbow Babies and is Interim Co-Chair of the Department of Pediatrics. She is the physician lead for a state-wide collaborative on Surgical Site Infection Reduction, a project of Solutions for Patient Safety.

Stephen Muething, MD Assistant Vice President for Patient Safety, Cincinnati Children's Hospital Medical Center

Kay K. Rietz, MEd, Assistant Deputy Director, Office of Children's Services, Ohio Department of Mental Health. Ms. Rietz manages programs and policies related to public mental health services for children and families in coordination with Ohio Family and Children First Cabinet agencies and community/university partners.

Lorin D. Ranbom, BA, Director of the Ohio Colleges of Medicine Government Resource Center. Mr. Ranbom directs a collaborative of Ohio's seven colleges of medicine to develop expertise regarding state and local governments managing health care services. Mr. Ranbom is also project director for the Ohio Family Health Survey.

Deborah Clement Saxe, Chief Bureau of Health Plan Policy, Ohio Department of Job and Family Services, Office of Ohio Health Plans. Ms. Saxe has over 20 years of program and policy development experience, including managing health services research for Ohio Medicaid.

Mike Schroeder, MSW, Clinical Safety Director, Ohio Department of Mental Health (ODMH). Mr. Schroeder serves as liaison with the Department of Developmental Disabilities and oversees the Mental Illness/Developmental Disabilities Coordinating Center of Excellence.

Lisa Simpson, MD, MPH, Director of the Child Policy Research Center, Cincinnati Children's Hospital Medical Center. Dr. Simpson is a Professor of Pediatrics at the University of Cincinnati College of Medicine and Director for Child Health Policy for the National Initiative for Children's Healthcare Quality.

Marion Sherman, MD Medical Director, Ohio Department of Mental Health. Dr Sherman is a psychiatrist with specialties in pediatric and adolescent care.

Gayle Channing Tenenbaum, BA, MSW, CEO, Channing & Associates. Ms. Channing Tenenbaum's consulting firm serves clients such as the Public Children Services Association of Ohio; Voices for Ohio's Children; and the Coalition on Housing and Homelessness in Ohio. She facilitates the Ohio Network for Child Safety.

Mary Wachtel, Director of Public Policy, Voices for Ohio's Children

Excerpted Support Letters - Ohio's CHIPRA BEACON Grant Proposal

Full text of these letters can be found at <http://www.odh.ohio.gov/landing/beacon/beacon.aspx>

"You have assembled a group that has the skills, experience, passion and dedication to... measurably improve care and outcomes for children and families...I would be honored to serve as the co-Chair of the BEACON Council as proposed in this application."

Alvin D. Jackson, MD, Director, Ohio Department of Health

"...I support the use of existing and proven resources to build networks that combine knowledge and experience with new and innovative ideas. The Office of Budget and Management stands firmly behind this effort and will provide...assistance...to ensure its success."

Pari Sabety, Director Office of Budget and Management

"We are especially pleased with the proposal's support for the newly created Center for Early Childhood Development within the Ohio Department of Education... to provide young children with the best chance for success in life by accessing quality health care for their full development."

John Stanford, Executive Assistant [to Governor Ted Strickland] for Education Policy

"The Ohio Federation for Children's Mental Health is ...pleased to support this opportunity to... improve healthcare for all children."

Terre Garner, Executive Director, Ohio Federation for Children's Mental Health

"We applaud... your interest in making integrated healthcare services available to Ohio's children and families...In light of the fact that Ohioans with mental illness are dying at least 25 years earlier than the general population, NAMI Ohio strongly supports efforts to integrate services" **James C. Mauro, Executive Director, National Alliance on Mental Illness of Ohio**

"The Ohio Health Information Partnership enthusiastically endorses the ...application...Health information exchange amongst partners is a key driver of the improvement science employed for quality initiatives proposed in the application."

Amy Andres, Chairperson, Ohio Health Information Partnership

"The behavioral health component of the...grant is the Ohio Pediatric Psychiatry Decision Support Network which will support continuous quality improvement...[and] standardization of practice protocols...ODMH...supports...the integration of physical and mental health care."

Sandra Stephenson, MSW, MA, Director, Ohio Department of Mental Health

"OACHC represents all 36 Federally Qualified Health Center grantees and "look-alikes" in Ohio...We... urge approval of your application."

Shawn K. Frick, President and CEO, Ohio Association of Community Health Centers

"An investment in Ohio will not only build the state's capacity...to ensure and sustain quality healthcare and outcomes for children but will also... inform other states' efforts."

Paul V. Miles, MD, FAAP, Senior VP for Quality, American Board of Pediatrics

"On behalf of the members of the Ohio Children's Hospital Association – Akron Children's Hospital, Cincinnati Children's Hospital Medical Center, Dayton Children's Medical Center,

Nationwide Children's Hospital), Rainbow Babies and Children's Hospital, and Toledo Children's Hospital – I express our support for the proposal.”

Nick Lashutka, President, Ohio Children's Hospital Association

[Full Children's Hospital letters at <http://www.odh.ohio.gov/landing/beacon/beacon.aspx>]

“On behalf of the Ohio Academy of Family Physicians [Representing approximately 4,400 practicing family physicians, residents and medical students] I am pleased to provide my enthusiastic support for the... proposal.”

Jeff Harwood, MD, President, Ohio Academy of Family Physicians

“...I have served on the Executive Committee of the Ohio Perinatal Quality Collaborative, one of the proposed grant projects...OPQC has produced some dramatic changes in care for pregnant women and newborns...since its inception... This example of an outcomes-focused...multi-institutional collaborative shows that clinicians, state government, improvement experts and families, working together..., can improve health outcomes.”

Craig Stafford, MD, Vice President of the American College of Obstetrics and Gynecology

“In 2009, the Ohio March of Dimes partnered with the Ohio Perinatal Quality Collaborative in...preventing pre-term births [by] educating parents and professionals on the importance of the final weeks of pregnancy and avoiding...scheduled deliveries via induction or C section. ...OPQC's quality improvement initiative {contained within this grant request} has received national attention.”

Karen Keller, State Director, March of Dimes Foundation, Ohio Chapter

“This proposal supports the mission of the American Academy of Pediatrics (AAP) to “attain optimal physical, mental and social health and well-being for all infants, children, adolescents and young adults...The rest of the nation will learn from your example.”

Errol R. Alden, MD, FAAP, Executive Director, American Academy of Pediatrics

“The Ohio Chapter, American Academy of Pediatrics, represent[ing] over 2,900 pediatricians ...stands...ready to assist the state in developing a system...that will bring about quality improvement all the way from the hospitals down to the practice level...”

Melissa Wervey Arnold, Executive Director, American Academy of Pediatrics, Ohio

“On behalf of the Quality Institute of the Ohio Hospital Association, I...express our support for the ... proposal...It has been my privilege to work ...with the [Ohio] Children's Hospitals on two quality improvement projects...They have proven results!”

David Engler, Ph.D, Vice President, Quality Institute, Ohio Hospital Association

“The ...recently created Ohio Health Care Coverage and Quality looks forward to coordinating and working with the proposed initiative.”

Cynthia Burnell, Executive Director, Ohio Health Care Coverage and Quality Council

“I am pleased to advise you of the Ohio Psychological Association's enthusiastic support for the...proposal...We...will do all we can to support efforts to expand and improve children's primary health care and behavioral health screening and referrals.

Michael O. Ranney, MPA, Executive Director, Ohio Psychological Association

“... We are particularly supportive of efforts [to create] ...comprehensive...healthcare homes for children with developmental delays and/or psychiatric, mental health needs...and use of innovative technologies to extend access to child psychiatry services...”

Hubert Wirtz, Chief Executive Officer, Ohio Council of Behavioral Health Care Providers

“Ohio has a nationally respected quality rating and improvement system...for licensed early care and education programs...[We] hope [this proposal] will encourage families to utilize a primary care physician.”

Terrie Hare, Chief, Bureau of Child Care & Development, ODJFS

“On behalf of the 20,000 physician, resident and medical student members of the Ohio State Medical Association, I am writing to express our support for the ... proposal... We strongly support the vision...to ensure quality health care...outcomes for children. ”

Roy H. Thomas, MD, President, Ohio State Medical Association

“...As a rural health network composed of child-serving systems in southeastern Ohio, we endorse Ohio's efforts to...improve care and outcomes for children...covered by Medicaid.”

Sherry Shamblin, Chair, Board of Directors, Integrating Professionals for Appalachian Children

“As Director of the Public Children's Services Association of Ohio, representing the 88 child protection agencies in our state, I am pleased to...support the...proposal...This proposal...will be of great assistance for our children and families.”

Crystal Ward Allen, Executive Director, Public Children Services Association of Ohio

“The Ohio Head Start Association will serve in a leadership role...and will connect the initiative with our local grantees to provide representation of local communities...identifying and engaging Ohio's most vulnerable families.”

Barbara Haxton, Executive Director, Ohio Head Start Association, Inc.

“We support your proposal...as we believe it will ...ensure quality health care and outcomes for children covered by Medicaid in Ohio, while...slowing the growth of healthcare spending”

Richard A. Stoff, President, Ohio Business Roundtable

“...Using the [Ohio Medicaid managed care] plans' audited HEDIS data will be valuable...to achiev[ing] best in nation results for birth outcomes, developmental trajectories and safe hospital care for children.”

Kelley McGivern, President and CEO, Ohio Association of Health Plans

“The Ohio Developmental Disabilities Council is pleased to support...the proposal...In these bleak economic times, it is efficient to build a new care model on an infrastructure which already exists... We look forward to working with you and other stakeholders.”

Carolyn Knight, Executive Director, Ohio Developmental Disabilities Council

“The OPPA...will be an active partner in this initiative...These efforts should ensure better mental and other physical healthcare integration...”

Brooke Wolfe, MD, President, Ohio Psychiatric Physicians Association

Letters of Support for Ohio's CHIPRA BEACON Grant Application January 7, 2010

#	Stakeholder Organizations	Individual Stakeholders / Members
	State Leaders	
1	Governor, State of Ohio	Ted Strickland
2	Leadership of the Ohio General Assembly:	President of the Senate, Bill Harris Speaker of the House, Armond Budish Ohio Senate Minority Leader, Senate Capri Cafaro Ohio House Minority Leader, William Batchelder
3	Ohio Office of Budget & Management	Pari Sabety, Director
4	Ohio Department of Education	John Stanford, Executive Assistant to the Governor for Education
5	Ohio Department of Health	Alvin Jackson, MD Director
6	Early Childhood Cabinet Agencies	Alicia Leatherman, Director
7	Ohio Health IT Advisory Board, Dept. of Insurance	Amy Andres, Chairperson
8	Ohio Family & Children First Council, First Lady Frances Strickland	Angela Sauser-Short, Director
9	Ohio Department of Mental Health	Sandra Stephenson, Director
	National organizations	
10	Institute for Healthcare Improvement,	Donald Berwick, MD, MPP, FRCP
11	American Academy Pediatrics,	Errol Alden, MD, FAAP
12	American Board of Pediatrics,	Paul Miles, MD, FAAP
13	American College Obstetricians & Gynecologists	J. Craig Strafford, MD, MPH, FACOG
	Ohio Organizations	
14	Cardinal Health Foundation, Dublin Ohio	Dianne Radigan, Director Community Relations
15	Federally Qualified Health Centers/Rural Health Centers	Shawn Frick, President, CEO
16	Ohio Business Roundtable	Richard A. Stoff, President
17	Ohio Children's Hospital Association	Nicholas Lashutka, President
18	Children's Hospitals / Other Hospitals	Rainbow Babies & Children, Cleveland
19		Children's Hospital, Cleveland Clinic
20		Nationwide Children's, Columbus
21		Cincinnati Children's Hospital & Medical Center
22		Toledo Children's
23		Mercy Children's Hospital, Toledo
24		Akron Children's
25		The Children's Medical Center of Dayton
24		OSU Medical Center, Department of OB/GYN, Dr. Jay Iams
25	Parent & Family Organizations	National Alliance for Mental Illness-Ohio Chapter
26		Voices for Ohio's Children
27		Ohio Federation for Children's Mental Health
28		Public Children's Services Association Ohio
29		March of Dimes, Ohio Chapter
30		Ohio Developmental Disability Council, Carolyn Knight, Director
31	Other Professional Organizations	Ohio Chapter of the American Academy Pediatrics
32		Ohio Hospital Association
33		Ohio Academy of Family Physicians
34		Ohio State Medical Association
36		Ohio Head Start Association
37		Ohio Psychological Association
38		Ohio Psychiatric Physicians Association
39		Ohio Council for Behavioral Health and Family Services Providers
40		Integrated Professionals for Appalachian Children
41		Ohio Association of Health Plans
44	Other Governmental Leaders & Councils	OH Health Care Coverage & Quality Council, Dept. of Insurance
45		Bureau of Child Care Development, Ohio Department of Job & Family Services



TED STRICKLAND
GOVERNOR
STATE OF OHIO

December 30, 2009

Mr. David Greenberg
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Greenberg,

As the Governor of the State of Ohio, I am pleased to provide my full support for Ohio's proposal through the Ohio Department of Job and Family Services for a CHIPRA Quality Demonstration Grant. For the past three years, my Administration has worked to expand access to care and improve the quality of care for Ohio's children and families.

The title of Ohio's proposal is **BEACON...Best Evidence for Advancing Childhealth in Ohio NOW.**

Our approach represents a fundamental shift in how public policy is designed and implemented. Ohio's proposal will utilize a collaborative governance framework and rely upon 'improvement science' with rapid feedback to achieve quality improvement. We believe that Ohio can provide a national model for quality care for Ohio's children.

Our priority is to achieve the best birth outcomes in the country, to set a national example for developmental screenings and collaborative practice with pediatricians, improve the quality of mental health care for children, and to provide the safest, most cost effective specialty hospital care for children. We have a strong focus on mental health as an integral part of health care for children and young adults. This builds upon the priorities of my administration, as we have developed an early care and development system that addresses the needs of the *whole* child.

The State of Ohio has an excellent history of working with our partners. This proposal engages a rich network of stakeholders, physicians and other providers, universities, business leaders and other key community leaders. Today this network includes the involvement of primary care practices including more than 700 physicians, the Ohio Chapter of the American Academy of Pediatrics, Ohio's nationally recognized Children's Hospitals, many child and family advocacy groups, and researchers from several of Ohio's universities, along with pertinent cabinet level agencies. Finally, as mandated in the CHIPRA legislation, the proposal also involves experimentation and evaluation of several promising ideas to improve the quality of children's healthcare and demonstrate improved outcomes.

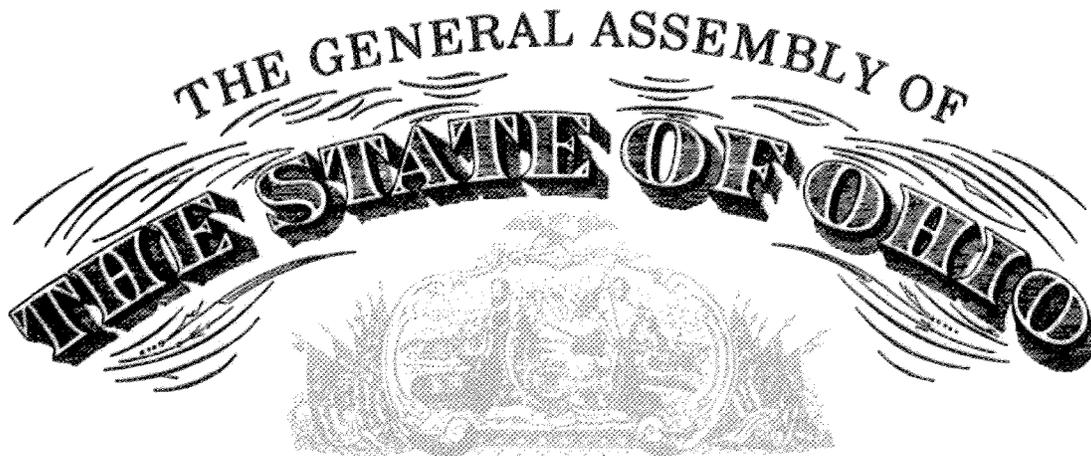
Page Two
December 30, 2009
Mr. David Greenberg

You will find that we have assembled an exceptional group of experts who have the skills, experience, passion, and dedication to work effectively to demonstrate improvements in care and outcomes for Ohio's children. My office is ready to assist this effort to reach our vision of ensuring quality healthcare and improving outcomes for the children and young adults we serve through our Medicaid and CHIP program.

Sincerely,

A handwritten signature in black ink that reads "Ted Strickland". The signature is written in a cursive style with a large, prominent "T" and "S".

Ted Strickland
Governor, State of Ohio



December 29, 2009

Tracy Plouck, State Medicaid Director
Ohio Dept. of Job & Family Services
Office of Ohio Health Plans
50 W. Town
Columbus, Ohio 43215

Dear Ms. Plouck:

We are writing to express our bi-partisan support for the Ohio Department of Job and Family Services' proposal to the U.S. Department of Health and Human Services for pediatric quality improvement resources through federal CHIPRA Quality Demonstration Grants.

The Ohio proposal aims to significantly and measurably improve care and outcomes for children in Ohio covered by Medicaid and the Children's Health Insurance Program. Ohio's proposed model utilizes an existing infrastructure of networks within Ohio throughout the entire spectrum of children's health care. These networks include family advocacy groups, pediatricians, perinatal providers, researchers, professional organizations, state agencies, and our world class children's hospitals. This is a group that has already delivered proven results through similar efforts and has the skills, experience, passion, and dedication to work effectively to measurably improve care and outcomes for children and families.

The proposed program builds upon past and current successful collaborative efforts among these organizations to create what we believe will become a national model for quality care for Ohio's youngest population. Through the systematic application of improvement science methods, the Ohio collaboration seeks to make Ohio a leader by achieving the best birth outcomes in the country, setting a national example related to developmental screening of children, improving the quality of mental health care for children and making Ohio the safest place in the country for children to receive hospital care. And, as mandated in the CHIPRA legislation, the proposal also involves experimentation and evaluation of several promising new ideas to improve the quality of children's health care and demonstrate improved outcomes.

Medicaid has many diverse constituents, none perhaps as important as those of our future - our children. With Medicaid and CHIP providing coverage to over 1.2 million Ohio children, initiatives such as this one are critical to ensuring Ohio is at the forefront of delivering world class children's health care. We strongly

support the vision your team has developed and believe it will build capacity and capability to ensure quality health care and outcomes for children covered by Medicaid in Ohio. You have our strong support.

Sincerely,



Bill Harris
President
Ohio Senate



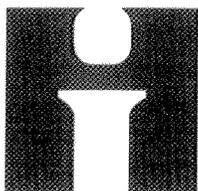
Armonio Budish
Speaker
Ohio House of Representatives



Capri Cafaro
Minority Leader
Ohio Senate



William Batchelder
Minority Leader
Ohio House of Representatives



INSTITUTE FOR
HEALTHCARE
IMPROVEMENT

December 21, 2009

Tracy Plouck
State Medicaid Director
Ohio Dept. of Job & Family Services
Office of Ohio Health Plans (Medicaid)
50 W. Town
Columbus, Ohio 43215

Dear Ms. Plouck,

I would like to provide my enthusiastic support and strong recommendation for the proposal that the Ohio Department of Job and Family Services will submit in response to the U.S. Department of Health and Human Services request for applications for the CHIPRA Quality Demonstration Grants. The Ohio proposal describes an excellent model that will establish and evaluate a national quality system for children's health care which encompasses care provided through the Medicaid program and the Children's Health Insurance Program (CHIP).

Ohio has developed programs that promise to provide best in class outcomes for prematurity, hospital safety, and children with behavioral and mental health issues. Funding the proposal would allow Ohio to accelerate its learning and improvement efforts and make this vision a reality. I believe that the Ohio proposal will be successful because it includes a results-driven team with outstanding improvement expertise that will focus on achieving measurable outcomes in care and health for children. Importantly, the focus on developing improvement capability and capacity throughout the state will provide an infrastructure that will sustain quality care and outcomes for children.

One of the members of the strong Ohio partnership, Cincinnati Children's Hospital Medical Center, is a strategic partner of the Institute for Healthcare Improvement. Cincinnati Children's keen focus on quality and safety has made them a national and international leader in quality and an excellent partner in the improvement journey. Cincinnati Children's will contribute its improvement expertise, innovation, and a culture of action to the Ohio collaboration.

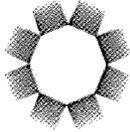
I most enthusiastically support the Ohio proposal. The Ohio collaboration involves a group with the skills, experience, passion, and dedication to work effectively to measurably improve care and outcomes for children and families. I support the vision that your group has developed and believe it will improve the lives of children, the health of communities, as well as the joy in the healthcare workforce in Ohio.

Sincerely,

Donald M. Berwick, MD, MPP, FRCP
President and CEO
Institute for Healthcare Improvement
Phone: 617-301-4891; Email: dberwick@ihi.org

(617) 301-4800

20 University Road
7th Floor
Cambridge MA 02138
Fax: (617)301-4848
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**VOICES FOR
OHIO'S CHILDREN**

December 7, 2009

Tracy Plouck
State Medicaid Director
Ohio Department of Job & Family Services
Office of Ohio Health Plans (Medicaid)
50 W. Town
Columbus, Ohio 43215

Dear Tracy,

Access and quality of health care has been one of the policy areas of Voices for Ohio's Children since its inception six years ago. We have worked on CHIP expansion, raising the eligibility level for pregnant mothers, simplification proposals and focused on the negative aspects of churning. We have also focused on the need for early childhood mental health programs. For these reasons we are very pleased to strongly support the Ohio Department of Job and Family Services 'proposal in response to the U.S. Department of Health and human Services Request for application for the CHIPRA Quality Demonstration Grants. This grant will allow our state to continue to move forward to strengthen our Medicaid and CHIP system for all children we serve and create a quality system with excellent outcomes.

Voices has a history of working in collaboration with Ohio's children's' hospitals, primary care physicians, and pediatricians as well as family advocacy groups to improve health outcomes for children. We welcome the opportunity to continue this work with these groups and the State of Ohio Office of Ohio Health Plans through this grant as we provide health care including mental health care with measurable outcomes for Ohio's children.

We are very pleased to lend our strong support to this grant and our promise of our full participation.

Sincerely,

Amy Swanson, Executive Director
Voices for Ohio's Children



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PH: 216-881-7860 FX: 216-881-7863
PH: 614-225-9073 FX: 614-228-5150
TOLL FREE: 877-881-7860

Cardinal Health Foundation
7000 Cardinal Place
Dublin, OH 43017

www.cardinal.com



December 28, 2009

Tracy Plouck
State Medicaid Director
Ohio Dept. of Job & Family Services
Office of Ohio Health Plans (Medicaid)
50 W. Town
Columbus, Ohio 43215

Dear Ms. Plouck:

On behalf of the Cardinal Health Foundation, I am writing to express our support for the Ohio Department of Job and Family Services' proposal to the U.S. Department of Health and Human Services for pediatric quality improvement resources through federal CHIPRA Quality Demonstration Grants.

As you may know, the Cardinal Health Foundation has provided some seed funding for our eight Ohio Children's hospitals to implement quality improvements to eliminate surgical site infections and adverse drug events. With this initial funding, we have seen these eight hospitals significantly strengthen their capacity – at all levels. We have been proud to support this formative work that built relationships, increased trust and transparency, strengthened infrastructure and is resulting in important quality improvements for Ohio children. Our aspiration is for Ohio to be The safest place for healthcare in the nation.

We believe we are on a path to make that aspiration a reality and we intend to continue to support this effort; however, more significant funding is needed to increase the depth and scope of the effort. There is much to be done to eliminate any and all errors. We believe the children's hospitals are now well-positioned to take this work to new levels. A CHIPRA Demonstration Grant would assure those further improvements become reality.

We strongly support the vision your team has developed and believe it will further build capacity and capability to ensure quality health care and outcomes for children covered by Medicaid in Ohio. Please feel free to contact me, or to have others contact me, for more information about this important work in Ohio.

Sincerely,



Dianne Radigan, Director Community Relations and the Cardinal Health Foundation
Cardinal Health