Improving Child Health Care Special Series:

**Improving Asthma Care**

Amy Belisle, MD, Medical Director, Quality Counts for Kids

Barbara Chilmonczyk, MD, Medical Director, AH! Asthma Health, Allergist/Immunologist, Allergy and Asthma Associates of Maine

Rhonda Vosmus, RRT-NPS, AE-C, AH! Asthma Health

Joined by

Susan Schow, MPH, PTE Program Director, Maine Health Management Coalition

Lisa Letourneau, MD, MPH, Executive Director, Maine Quality Counts, Consulting Medical Director to Maine Health Management Coalition

Conf Call: 866.740.1260, ID: 6223374
Who We Are

Maine Quality Counts (QC) is a regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality throughout Maine.
Our Mission

QC is transforming health and health care in Maine by leading, collaborating and aligning improvement efforts.

• Maine Patient Centered Medical Home Pilot
• Community Care Teams
• Aligning Forces for Quality (AF4Q)
• Behavioral Health Integration
• Quality Counts for Kids / First STEPS initiative
• Transforming Care at the Bedside
QC Learning Community Webinars

- Monthly webinars:
  - Provider Lunch & Learn: 1st Tues/mo – 12N
  - HIT Roundtable: 2nd Thurs/mo – 12N
  - QC 2013 Triple Aim Series: 3rd Thurs/mo – 12N
  - QC Brown Bag Forum: 4th Tues/mo – 12N
Important Webinar Notes

• If you are not speaking, please mute your phone by pressing *6

• Please do NOT put your phone on hold (many phone systems use music on hold)

• To ask questions or share comments, use one of two ways:
  • Use the “Raise your hand” function on the webinar and ask question by phone (un-mute your line by pressing *7)
  • By computer: Type your question or comment into the “Chat” box on the lower left-hand side of the screen

• When asking questions or sharing perspectives or insights via phone, please state your name and organization before asking your question or sharing your comment.

Thank you!
Today’s Session:

**Amy Belisle, MD, FAAP**
Dr. Belisle is the Director of Child Health Quality Improvement at Maine Quality Counts, Quality Counts for Kids, and is part of the Improving Health Outcomes for Children (IHOC) staff working on the CHIPRA grant. Dr. Belisle is a pediatrician who served in the Air Force and was a Pediatric Hospitalist at CMMC. From 2009-2010, she was the physician leader for the Maine AAP CQN Asthma Pilot, a practice improvement collaborative with 12 Pediatric sites across the state. Currently, she is directing a three year learning collaborative called First STEPS (Strengthening Together Early Preventive Services). She is helping build a Maine Child Health Improvement Partnership (ME CHIP) which serves as an advisor to the MHMC Pathways to Excellence Program on child health care quality metrics.

**Barbara Chilmonczyk, MD, FAAP**
Dr. Barbara Chilmonczyk is an Associate Professor of Pediatrics at the Tufts University College of Medicine and the division director for Allergy and Immunology at The Barbara Bush Children’s Hospital at Maine Medical Center. From 2009-2010, she was a national and state asthma expert for the Maine AAP CQN Asthma Pilot, a practice improvement collaborative with 12 Pediatric sites across the state. In addition to her current work with Allergy and Asthma Associates and the division of Allergy and Immunology, she serves as the medical director for the AH! Asthma Health Program at Maine Medical Center.

**Rhonda Vosmus, RRT-NPS, AE-C**
Rhonda Vosmus is a nationally certified asthma educator who provides patient/family, provider and community asthma education at Maine Medical Center and the Greater Portland Community. She has been in the field of respiratory care 30 years as a critical care therapist and educator. Rhonda is currently a board member of the American Lung Association of Maine. She has served as an advisor for the National Lung Association for curriculum development for the Asthma Educator Institute. Rhonda participates in local, regional and national initiatives surrounding asthma care.
Agenda

• Outline the updated 2012 PTE metrics for asthma and answer questions about metrics
• Identify the tools needed for the metrics
• Discuss why Spirometry is Important
• Highlight Spirometry Basics
New

Pathways To Excellence
Asthma Metrics
September 2012

Previous ratings for metrics will expire July 1, 2013

- Asthma Assessment
- Lung Function Testing
- Medication Therapy
- Influenza Vaccine
- Asthma Action Plans
- Tobacco Exposure & Use
- Documented BMI
Reporting Requirements for PTE

• Can report from EMR/registry or by chart review
• Population based reporting (from a registry or EMR) gives you 10 additional points.
• Can only get “best rating” with population based reporting.
• Chart Review- 30 charts total. 10 charts for kids ages 2<5 and 20 charts for kids ages 5<19
• Current PTE ranking lasts 2 years
How to Score a Measure

• Scoring based on Bridges to Excellence scoring system
• This year, the total number of points needed to achieve good, better, best was decreased in recognition of lower point totals with population based reporting and new metrics (like spirometry)
• For each metric, you get a % of maximum points:
  - For example, for asthma assessment, there are 15 points assigned to the metric
  - If 15/30 kids had an asthma assessment done, you would get 7.5 points for that metric
• An Excel version with formulas to calculate points is on the PTE website at http://www.mehmc.org/pediatric-technical-specifications.html under (under Asthma Item “a”)
## PTE Pediatric Asthma Metrics and Scoring, Updated September 2012

<table>
<thead>
<tr>
<th>Asthma Measures</th>
<th>NUMERATOR</th>
<th>DENOMINATOR (Note: for practices doing manual chart review, must be ≥ 10 charts for ages 2&lt;5 and ≥ 20 charts for ages 5&lt;19)</th>
<th>Practice Rate</th>
<th>Max Points for Measure</th>
<th>Practice Points Achieved (Practice Rate multiplied by Maximum Points Available)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Asthma Assessment</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>2. Lung Function Testing</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>(Note: Ages 5&lt;19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medication Therapy</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>4. Influenza Vaccination</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>5. Patient Self Management Plan</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>6 Documented Tobacco Exposure/Use</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>7. BMI %</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Total Points Available/Received</strong></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
| 8. Population Based Reporting-EMR/Registry for all asthmatics? | Yes/No | Yes  = 10  
No = 0                                                                                   |               |                        |                                                                                 |
| **Total points for Population-Based reporting (if applicable)** | |                                                                                                                 |               |                        |                                                                                 |

* The points for each category are rounded to the next whole number.
** Best is only achievable for those reporting their total population regardless of the final score.

MHMC Rating (Good, Better, Best)  
Good ≥ 45 Points □  
Better ≥ 65 Points □  
** Best ≥ 75 Points □
PTE Asthma Measure Selection

- Aligns with 2007 NHLBI Asthma Guidelines
- Use national measure sources
  - Current PTE Asthma Metrics
  - Bridges to Excellence Asthma Metrics
  - National Quality Forum (NQF)/AMA/NCQA
  - Meaningful Use
- Attempt to align numerators/denominators
- Metrics are for all children with asthma except for chronic medication management which is for persistent only
- Keep age groups as simple as possible
  - 2<5 yrs and 5<19 yrs
Instituting 2007 NHLBI Asthma Guidelines in Primary Care

- **Age groups** are subdivided:
  - 0-4yrs
  - 5-11yrs
  - >12yrs
- **Severity** (classification) for starting treatment:
  - Impairment
  - Risk
- **Control** emphasized for monitoring and adjusting therapy
- **Spirometry** recommended for all > 5yrs

An Easy Resource: AH! Flip Chart

Asthma Clinical Guidelines

Adapted from the National Heart, Lung, and Blood Institute’s (NHLBI) National Asthma Education and Prevention Program (NAEPP) 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma

Goals of Asthma Treatment

Patients will:

- Be free from troublesome symptoms day and night, including sleeping through the night.
- Have the best possible lung function.
- Be able to participate fully in any activities of their choice.
- Not miss work or school because of asthma symptoms.
- Need fewer or no urgent care visits or hospitalizations for asthma.
- Use medications to control asthma with as few side effects as possible.
- Be satisfied with their asthma care.

It is also important to determine the patient’s personal treatment goals and preferences for treatment. Ask how asthma interferes with the patient’s life (e.g., inability to sleep through the night, play a sport), and incorporate the responses into personal treatment goals. Involve the patient in decision-making about treatment.

MaineHealth
AH! Asthma Health

http://www.mainehealth.org/mh_body.cfm?id=6596
How is Asthma Defined?

To establish a diagnosis of asthma, the clinician should:

• Use a medical history and exam to determine if present:
  – Symptoms of variable and recurrent episodes of airflow obstruction
  – Airway hyper responsiveness
  – Underlying inflammation
  – In susceptible individuals, this inflammation causes recurrent episodes of coughing (particularly at night or early in the morning), wheezing, breathlessness, and chest tightness. *(Source: p. 9 of Abridged NHLBI Guidelines)*

• Use spirometry in all patients 5 years or greater to determine the level of airflow obstruction and assess reversibility

*(Source: Differential Diagnosis for Asthma, AH! Program Flipchart, p. 3)*
When Making Diagnosis of Asthma, Exclude Alternative Diagnoses:

- **Upper Airway Disease** - allergic rhinitis and sinusitis;

- **Obstruction of the large airways**: foreign body in trachea or bronchus, vocal cord dysfunction, vascular ring or laryngeal web, laryngotracheomalacia, tracheal stenosis, or bronchoostenosis, enlarged lymph node or tumor;

- **Obstructions involving small airways**: viral bronchiolitis or obliterative bronchiolitis, cystic fibrosis, bronchopulmonary dysplasia, heart disease;

- **Other causes**: recurrent cough not due to asthma, aspiration from swallowing mechanism dysfunction or gastroesophageal reflux)

(Source: Differential Diagnosis for Asthma, AH! Program Flipchart, p. 3)
PTE Measure: Asthma Assessment

• % of patients with a diagnosis of asthma (ages 2 <19) who were evaluated during at least one office visit within 12 mo for daytime and nocturnal symptoms

• Adapted National Quality Forum (NQF) Metric #001

• Recommend use of the Asthma Control Test (ACT) > 4 years and TRACK 2<4 years

• Looking for documentation of at least 2-4 weeks of asthma symptoms
  – ACT is 4 weeks, TRACK is 4 weeks, 3 months, 12 months
Asthma Control Test (ACT)

Tips on ACT
• Use it to start a conversation with family
• A score of 19 or less may indicate poor control
• Want to follow score over time
• Not a good tool during an acute exacerbation

Children's Asthma Control Test for children 4 to 11 years old.

Know the score.
This test provides a score that may help your doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test
Step 1: Have your child complete these questions. For each question, your child will rate how much of a problem it is to them.

1. How is your asthma today?
   - Very bad
   - Bad
   - Good
   - Very good

2. How much of a problem is your asthma when you run, exercise or play sports?
   - It's a big problem, I can't do what I want to do.
   - It's a problem and I don't like it.
   - It's a little problem but it's okay.
   - It's not a problem.

3. Do you cough because of your asthma?
   - Yes, all of the time.
   - Yes, most of the time.
   - Yes, some of the time.
   - No, none of the time.

4. Do you wake up during the night because of your asthma?
   - Yes, all of the time.
   - Yes, most of the time.
   - Yes, some of the time.
   - No, none of the time.

5. During the last 4 weeks, on average, how many days per month did your child have any daytime asthma symptoms?
   - Not at all
   - 1-3 days/mo
   - 4-10 days/mo
   - 11-18 days/mo
   - 19-24 days/mo
   - Everyday

6. During the last 4 weeks, on average, how many more days per month did your child have asthma during the day because of asthma?
   - Not at all
   - 1-3 days/mo
   - 4-10 days/mo
   - 11-18 days/mo
   - 19-24 days/mo
   - Everyday

7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of asthma?
   - Not at all
   - 1-3 days/mo
   - 4-10 days/mo
   - 11-18 days/mo
   - 19-24 days/mo
   - Everyday

Please turn this page over to see what your child's total score means.

Tools on the AH! Website under Clinical Tools at http://www.mainehealth.org/mh_body.cfm?id=363
TRACK™ Test for Respiratory and Asthma Control in Kids

Who should use TRACK?
This simple test can help determine if your child’s breathing problems are not under control. The test was designed for children who:
• Are under 5 years of age AND
• Have a history of 2 or more episodes of wheezing, shortness of breath, or cough lasting more than 24 hours AND
• Have been previously prescribed bronchodilator medicines, also known as quick-relief medications (e.g., albuterol, Ventolin®, Proventil®, Maxair®, ProAir®, Xopenex®), for respiratory problems OR
• Have been diagnosed with asthma

For kids under 5 years of age

How to take TRACK
Step 1: Make a check mark in the box below each of your selected answers.
Step 2: Write the number of your answer in the score box provided to the right of each question.
Step 3: Add up the numbers in the individual score boxes to obtain your child’s total score.

Score

1. During the past 4 weeks, how often was your child bothered by breathing problems, such as wheezing, coughing, or shortness of breath?
   - Not at all
   - Once or twice
   - Once every week
   - 2 or 3 times a week
   - 4 or more times a week
   - 0

2. During the past 4 weeks, how often did your child’s breathing problems (wheezing, coughing, shortness of breath) wake him or her up at night?
   - Not at all
   - Once or twice
   - Once every week
   - 2 or 3 times a week
   - 4 or more times a week
   - 0

3. During the past 4 weeks, to what extent did your child’s breathing problems affect how he or she felt while doing daily activities? Interfered with his or her ability to play, go to school, or engage in usual activities that a child should be doing at his or her age?
   - Not at all
   - Slightly
   - Moderately
   - Quite a lot
   - Extremely
   - 0

4. During the past 3 months, how often did your child need to take oral corticosteroids (prednisone, prednisolone, Orapex®, Flutone®, or Decadron®) for breathing problems not controlled by other medications?
   - Not at all
   - Once or twice
   - Once every week
   - 2 or 3 times a week
   - 4 or more times a week
   - 0

5. During the past 12 months, how often did your child need to take oral corticosteroids (prednisone, prednisolone, Orapex®, Flutone®, or Decadron®) for breathing problems not controlled by other medications?
   - Never
   - Once
   - Twice
   - Three times
   - Twice or more
   - 0

Total

What does your child’s TRACK score mean?

If your child’s score is
Less than 80
Your child’s breathing problems may not be under control
• Make sure you are following the treatment recommendations given to you by your child’s health care provider
• Talk with your child’s health care provider about reasons why your child’s breathing problems may not be under control
• Ask your child’s health care provider what steps might be taken to improve your child’s respiratory and asthma control in order to reduce daytime and nighttime symptoms and to reduce the need to use quick-relief medications

If your child’s score is
80 or more
Your child’s breathing problems seem to be under control
• Monitor your child’s breathing problems on a regular basis and bring any concerns to the attention of his or her health care provider. Even though your child may not have breathing problems right now, these can come and go at any time
• Continue talking with the health care provider about your child’s progress and which treatment plan is right for your child
• Good respiratory and asthma control can help your child sleep better, participate in everyday activities, and suffer fewer recurrent flare-ups of breathing problems

Talk to your child’s health care provider about your child’s TRACK score

The American Academy of Pediatrics (AAP) Quality Improvement Innovation Network (QuIN) participated in the validation of this tool

AstraZeneca

http://www.mainehealth.org/workfiles/mh_professional/Asthma/TRACK.pdf
PTE Measure: Medication Therapy

• % of patients ages 2 < 19 who were identified as having persistent asthma and were appropriately prescribed controller medication (adapted NQF #36)

• Persistent: any patient on a prescribed daily medication is persistent even if symptoms are controlled
Definition of Persistent Asthma

• Symptoms >2 days per week **OR**
• Awaken at night from asthma 1-2X per month for children ages 2 <5 years and >2X per month ages 5 <19 years **OR**
• Limitation of activities, despite pretreatment for exercise induced asthma **OR**
• More than 2 steroid bursts in 1 year **OR**
• FEV1 <80% predicted **OR** low FEV1/FVC ratio

*This definition of persistent asthma describes symptoms present at the time of diagnosis; once patients are treated, symptoms are expected to be controlled*

If a patient is treated, you can use the amount and type of medication to help define classification; then the patient should be followed to make sure he/she is controlled

(Source: AH! Program Flipchart)
PTE Measure: Influenza Vaccination

• % of patients with a diagnosis of asthma ages 2 <19 who have documented flu shot within the last 12 months

(All children >6 months are recommended to get a flu shot)
PTE Measure:
Self Management Plan or Action Plan

• % of patients with a diagnosis of asthma ages 2 < 19 years that have a current written action plan on file updated within the last year
Example of an Asthma Action Plan

Maine Asthma Action Plans are available from the Maine Asthma Program. Call 207-287-3041 or email desirae.severson@maine.gov
PTE Measure: Tobacco Exposure and Use

• % of patients with a diagnosis of asthma ages 2 <19 years with annual documentation of tobacco exposure/tobacco use
• Tobacco exposure is defined as someone who uses tobacco in the household or is a primary caregiver
PTE Measure: BMI% and Asthma

- % of patients with a diagnosis of asthma ages 2 and <19 with BMI% documented
- Research ongoing
- If you are overweight, it is harder to exercise
- If you can’t exercise due to asthma, more likely to be overweight
PTE Measures: Lung Function Testing (Spirometry)

- % of patients with a diagnosis of asthma ages 5–<19 years in which one or more spirometry results have been obtained within the past 24 months
- Will need to document that some are physically unable to do test
- Moderate or Severe Persistent Asthmatics may need to have spirometry done more frequently than every 2 years
- This metric is for all children with asthma
What is Spirometry?

Spiro (to breathe) meter (to measure)

• Spirometry is a measure of how much (volume) and how fast (flow rate) somebody can exhale after taking the deepest breath she can.
• It is an effort dependent test which means the patient needs to give her best effort for the test to be useful.
• FVC (forced vital capacity), FEV$_1$ (forced expiratory volume in 1 second), and FEF$_{25-75}$ (forced expiratory flow in the middle half of the effort).
• With proper coaching, spirometry can be performed by children over age 4.

www.jonesmedical.com/spirometry101/what.asp
Why Do Spirometry?

2007 NHLBI guidelines:

• Medical history and physical examination are not reliable means of excluding other diagnoses:
  – Intrathoracic obstruction vs. Restriction
  – Extrathoracic obstruction vs. Intrathoracic obstruction

• Physicians have poor ability to assess degree of airflow obstruction (Russell et al 1986) and to predict whether obstruction is reversible (Nair et al 2005)

• Up to 1/3 of children will be classified with more severe asthma if spirometry is performed (Stout et al. 2006)

• Peak Flow meters are designed for monitoring not diagnosing; spirometry can confirm Peak Flow measures
Why Spirometry (cont)

• One of the only objective tools we have for diagnosis
• Low FEV1 is a predictor of future exacerbations
• Helps to identify the poor perceiver and the over perceiver
• #'s can be helpful for families
• 35% of pediatricians use spirometry* (compared to 75% of Family Practice)

Relationship Between Airway Obstruction and Respiratory Symptoms

- 67 adolescent/adult asthmatics
- Six asthma symptoms were measured
- Spirometry was measured
- Study replicated in pediatric populations

Chest 1998;113:272-7
Can Primary Care Practices Do Spirometry?

Data from the Maine AAP CQN Asthma Pilot 2010

Maine = 65%

Hospital Based Practice

Private Practice
Where and How Should Spirometry Be Done?

- Primary Care Office or PFT Lab or Specialist Office
- Initial spirometry should be pre and post metered dose inhaler (MDI)
- Follow-up spirometry tests do not need to include pre and post bronchodilator challenge unless indicated
- Testing should be done without beta agonist for 6 hrs prior to test; 12 hours for long acting beta agonist
- For PTE, a primary care office can count that spirometry has been done by a specialist if there is documentation in the chart (it does not need to be repeated in the primary care office)
Spirometry Measurements

- **Forced Vital Capacity (FVC)**
  - Measures amount of air a patient can blow forcefully from maximum inhalation
  - Not the total amount of air found in the lung

- **Forced Expiratory Volume in One Second (FEV₁)**
  - Volume of air forcefully blown in the first second of expiration during the FVC maneuver
  - Abnormal flows in the small airways may be detected before FEV₁ is reduced

- **FEV₁ / FVC ratio (FEV₁ ratio or FEV₁%)**
  - Expressed as a percentage of FVC
  - Helps define restriction vs. obstruction
Normal Values for Spirometry - Children -

- FVC greater than/equal to 80% predicted
- FEV$_1$ greater than/equal to 80% predicted
- FEV1/FVC (Flow rate) $\geq$ .85 (85%)
- Affected by:
  - Height: taller = larger lungs
  - Sex: males > females
  - Age: declines with age
  - Race: African-Americans have smaller lungs (-12%)
Obstructive Airflow Pattern

- Concave shape of curve
- FEV$_1$ low
- Decrease in FEV$_1$/FVC to less than 85% in kids
- Decreased FEF$_{25-75}$
- Peak flow may be low
- A patient may have normal spirometry and still have intermittent or mild disease
Why Spirometry is Important

- Eight year old with coughing and wheezing with some colds
- Shortness of breath and cough during soccer practice... at a grass/weed covered field
- Rides bike fine; last week woke up at night with coughing
- History of intermittent sneezing
- Mom smokes and has hx of asthma; father has hay fever
- Pre and post bronchodilator (4 puffs albuterol)
- FEV1 pre = 80% predicted
- FEV1/FVC=.79
- 16% increase in FEV1 post bronchodilator
Insurance Coverage of Spirometry

• Should be covered by insurers
• Some families are charged if part of a high deductible plan or hadn’t met deductible yet
• Cost savings: Spirometry costs $42 according to HealthcareBlueBook.com; MaineCare reimburses between $20-25
• Unnecessary use of inhaled corticosteroid can cost $200 to $300 a month
• An ED visit for an asthma attack can total $3500
• Asthma costs the US more than $56 billion per year

Choosing Wisely, Consumer Reports Health, 2012
Asthma

• You can report new PTE asthma metrics now; current ratings are in place until July 2013

• More information is available on the Maine Health Management Coalition website including a spirometry handout at: http://www.mehmc.org/pediatric-technical-specifications.html

• Spirometry Tips:
  – Classification is better
  – It can improve care for our patients
  – It can be done in the office or at the hospital—either way OK
  – A more in depth webinar on spirometry specifics/interpretation will be done in the future for those interested
Questions?
Questions We Are Getting

• Do children with intermittent asthma need spirometry?
• What do we do with the teenagers who have exercise induced asthma?
• When do we classify a child as an asthmatic? Wheezing vs. cough? How many episodes?
Contact Information

**Susan Schow, MPH**
PTE Program Director, MHMC  
207-899-1971 Ext. 232  
sschow@mehmc.org

**Amy Belisle, MD**
Director of Child Health Quality Improvement  
Maine Quality Counts  
abelisle@mainequalitycounts.org  
207-847-3587

**Lisa Letourneau, MD, MPH**
Executive Director, Maine Quality Counts  
Consulting Medical Director to MHMC  
iletourneau@mainequalitycounts.org

**Rhonda Vosmus, RRT-NPS, AE-C**
*AH! Asthma Health Program*
Nationally Certified Asthma Educator  
vosmur@mmc.org  
662-4515
ME CHIP is currently funded by a CHIPRA/IHOC Quality Demonstration Grant
February 2010 to February 2015

• The Improving Health Outcomes for Children (IHOC) work is conducted under a Cooperative Agreement between the Maine Department of Health and Human Services and the Muskie School of Public Service at the University of Southern Maine and is funded by a grant from the Centers for Medicare and Medicaid Services (CMS) through Section 401(d) of the Child Health Insurance Program Reauthorization Act (CHIPRA). This document was developed under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

• For more information, please contact the IHOC Project Director, Joanie Klayman at jklayman@usm.maine.edu or 207-780-4202.