Children's Health Insurance Program Reauthorization Act (CHIPRA) Demonstration Project

Category A Provider Interviews

Summary of Qualitative Findings

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1. Introduction

A. Project Background

In 2010, Massachusetts became one of ten grantees (18 states) participating in a five-year quality demonstration project established under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The Massachusetts CHIPRA project (Project) has been led by five partners – Massachusetts Medicaid (MassHealth), Boston Children's Hospital, University of Massachusetts Medical School (UMMS), Massachusetts Health Quality Partners (MHQP), and the National Institute for Children's Health Quality (NICHQ). The demonstration seeks to develop innovative approaches to improving the quality of care for children.

Massachusetts was awarded the grant to:

- Administer and evaluate the use of 24 core measures for children's healthcare quality ("Core Measures") endorsed by the Centers for Medicare and Medicaid Services (CMS) (Category A);
- Support the implementation of a medical home model of care at select child-serving practices across Massachusetts (Category C); and
- Convene a Statewide Child Health Quality Coalition to lead transformational health improvements for the children of Massachusetts, and to identify gaps in pediatric quality measures (Category E).

This report focuses on Category A. The Category A component of the demonstration, led by MHQP, is focused on collecting data and calculating results for the CHIPRA Core Measures set at two points in time, Cycle 1 and Cycle 2. An additional objective of the Category A component is to explore the ways in which measures results can be shared with relevant stakeholders. As such, several reports were generated: the CHIPRA Practice Report, the CHIPRA Family Report, and the CHIPRA Statewide Report. The goal of the CHIPRA Practice Report is to share comparative data with practices on their performance on a subset of the Core Measures set issued by CMS and the Agency for Healthcare Research and Quality (AHRQ). The Core Measures set includes a range of children's health care quality measures encompassing both physical and mental health domains. The CHIPRA Practice Report provides practice-level results for MassHealth and commercially-insured patients compared to statewide benchmarks.

This report presents a summary of findings from interviews with providers to evaluate the utility and relevance of the Cycle 1 CHIPRA Practice Report to stakeholders. The Evaluation Team at UMMS developed a descriptive evaluation design consisting of semi-structured interviews with providers. The Evaluation Team sought to answer the following questions:

1. Do providers <u>value</u> the information in the report?

2. How and to what extent would providers use the report?

Providers were also asked to provide feedback on the format and content of the CHIPRA Practice Report including whether it was helpful to have their measure results reported separately for their MassHealth and commercially-enrolled patients.

It is important to note that the CHIPRA Practice Report was initially generated and distributed for the purposes of this evaluation and has not been more widely distributed at the time of this report. As a result, the Evaluation Team could not assess the extent to which providers were knowledgeable or aware of the CHIPRA Practice Report, one of the evaluation questions identified in the initial evaluation plan.

B. Sample Selection

Interviews were conducted with a total of 10 providers across the state. The Evaluation Team determined that semi-structured interviews with a sample of ten providers would yield sufficient data to generate overarching themes. In order to maximize provider participation in the interviews, the Evaluation Team selected a convenience sample. The Evaluation Team leveraged a list of 10 providers whose practice site had participated as a comparison site for the Category C CHIPRA Medical Home Demonstration, since these practices might be more likely to participate due to their familiarity with the project. The list of 10 practices was then matched to a master list of practices eligible to receive the CHIPRA Practice Report (N=552). Only practice sites consisting of two or more providers with a minimum of ten patients in at least one measure denominator were eligible to receive a report. If the practice site did not meet these criteria for a given measure, then no performance score was produced for that measure.

Nine of the 10 selected practices were found on the master list and ultimately 6 of these practices participated. To identify a tenth practice as well as develop a contingency plan in the event that one or more of the sites refused participation, CHIPRA Practice Reports were generated for 41 more practices. Practices were then randomly selected from each of the 6 regions of the state. Practices with less than 8 measures reported and practices participating in MassHealth's Primary Care Payment Reform were excluded from participation. Each region was represented in the interviews; however, due to provider availability, the final distribution of interviewees only included one practice site for Boston, Southeast, and Western Massachusetts. The number of measures reported for each practice varied with the minimum being 8, the maximum being 20, and the mean being 15.

Table 1: Practice Site Sample Characteristics

Practice Location	Number of Sites (Total N=10)
Boston	1
Metro West	2
Central	2
Northeast	3
Southeast	1
Western	1

C. Outreach and Data Collection

Respondents were contacted via email and phone to schedule interviews. A maximum of three contact attempts was made before a new site was selected. A total of 5 practices did not respond or refused participation and replacement sites were identified. Interviews were conducted over the phone at a time convenient for the interviewees and lasted between twenty to forty minutes. Interviewers requested and received permission to audio-record each interview session. Verbal consent from interviewees was obtained prior to conducting interviews. No incentives were provided for participation.

Interviewers used a semi-structured interview guide to collect information specific to the evaluation aims. Questions covered the following topics: what was useful/not useful about the report; what measures were useful/not useful, and how they would use the report. Sub-questions or prompts were applied to each topic in order to obtain provider feedback on all sections of the report.

D. Data Preparation and Analysis

Audio recordings were transcribed into Microsoft Word by a contracted transcription service. Each transcript was reviewed by a team member to assure completeness and accuracy. Transcripts were then uploaded into Atlas.ti Version 7.1, a software program that aids in qualitative analysis.

To guide the analysis, the Evaluation Team developed a codebook and coding scheme based on the evaluation questions and emerging themes. To ensure inter-reliability, all transcripts were coded by a primary and secondary coder who reviewed each other's coded transcripts to ensure consistent code application. Coding disagreements were resolved via discussion and additional data review until consensus was achieved. The Evaluation Team then met to review each other's identification of themes in order to reach agreement on how to present them. The themes arising from this analysis are the basis of this report.

2. Findings

A. Report Design

Providers were first asked to comment on what they found useful or not useful about the CHIPRA Practice Report. Additional questions asked for their opinions on the inclusion of payer-specific data and the overall report design. Feedback on the quality measures is provided in Section 2B of this report.

Report Descriptions and Appendices: The majority of interviewees responded favorably to the layout and informational materials included in the report, often making comparisons to reports they receive from other sources. Most of the respondents noted that the report was easy to read and understand, and that the measure descriptions and technical appendix helped them to understand what was being presented and how the measures were calculated.

> *I like it. I like the descriptions of what they're measuring. I liked everything about this report, basically, because I deal with reports all the time…They're really difficult to follow. I wish they all had a format like this, because this makes life so much easier when you can understand what you're supposed to be working for.* (Practice 2)

Interviewees also described the information in the report as comprehensive, and adequate to answer any questions that might arise while reading the report. For those who found the CHIPRA Practice Report similar to other reports they receive, the references were particularly useful for comparing and understanding why the data may be different. They also appreciated that there was no need to consult another source for the measure specifications.

> *I find it really easy to read and really easy to understand…there's so much verbiage there that if I have any questions, I'm almost certain that the answers will be contained in them. I think the report is well-designed for any user. We're experienced users of these kinds of reports. We've gotten them for years and years and years, and I know exactly what I'm looking at versus another practice who may not be as familiar with this kind of data and what to do with it.* (Practice 4)

> *…I think the fact that you have the measure descriptions right in the report, if I had a question, I could just click right over just to see what your criteria were instead of saying, "I know you're using NCQA [National Committee for Quality Assurance] criteria." Having it right there, because we think we know them, but then you're like, "Oh, wait a minute."…so it is great to have that access on the same report that you're looking at instead of having to go to a different program to find out what the measures are.* (Practice 5)

Moreover interviewees suggested that the references provided context around what the measures mean and why it is important to collect them. The clinical impact section was highlighted as particularly helpful by a few respondents.

> *I like that you have the clinical impact listed on your measures…I think that's a huge help and that would be great for staff, too. Because we do talk to staff about importance and why you do it, but a lot of this information would be excellent for them.* (Practice 5)

In contrast, a few interviewees indicated that because they already receive similar reports from other sources, they found the content of the CHIPRA Practice Report duplicative and redundant.

> *Well, to be honest, it seems like nowadays providers get reports from all over the place. I think they lose track where it's coming from. Is it coming from meaningful use? Is it internal? Is it external? I have to admit that providers are not really asking to have more measures at this point. It's almost like, could all the people who are reporting get together and be in the same boat and report on the same measures, unless there's some special focus that makes having the differences necessary? I guess what I'm trying to say, there seems to be a lot of redundancy these days.* (Practice 3)

Some interviewees also thought some of the information, such as the methodology section, was superfluous and added unnecessary length to the report.

> *I think the length of it, at first it was a little bit intimidating. When you get a big attachment that's 32 pages, sometimes that can be a little bit scary. I realize that a lot of it was more explanatory and the information that was pertinent to our practice was actually not that much.* (Practice 3)

Data Presentation and Benchmarks: Interviewees thought the data was presented very clearly compared to other formats, such as Excel spreadsheets. A few particularly appreciated the use of symbols, stating it allowed for a quick review of performance.

> *I think it's great. It's easy to read. I really like the comparison symbol legends because you can do sort of a quick perusal, and it's a quick way to identify areas that we might really need to be focusing on in the next reporting period. That's always great…* (Practice 4)

The majority of interviewees indicated that the statewide benchmarks were helpful and allowed for comparisons between individual practices and state performance. Those comparisons helped practices place their rates into context. By identifying areas where they might be an outlier, practices could identify areas for improvement.

> *It's certainly the comparison to our group…as well as the comparison to the Massachusetts rate. That's always helpful to us because in isolation, obviously, it's hard to discern. Is 98 percent good, or is it great? Certainly, that's helpful.* (Practice 4)

> *I think it was helpful to see where some of the data showed some outliers and it made it—it made me think about, "Oh, why is that happening?" I think in that sense those type of messages got across.* (Practice 3)

When asked about the data breakdown by payer type, provider opinions were mixed. Not all provider reports contained commercial and MassHealth data, but all providers were asked if they thought the breakdown was or would be useful. In general, interviewees indicated that they liked the measure breakdown by payer and thought that it provided interesting data. Respondents indicated that because they also receive similar information from other payers it was helpful to have all the information summarized on one page for comparison purposes.

> *It's always good to compare, right? It's always good to see yourself in a frame that you don't typically see yourself in. I mean, we do a lot of our own measurement and a lot of our own quality, but it's nice to see it from an external source.* (Practice 9)

Other respondents suggested that it could help providers assess if there are differences or disparities in care delivery between public and commercially insured members. At least one interviewee noted that the breakdown may impact some measures more than others. For example, MassHealth requires behavioral health screenings during well-child visits and does not require a co-pay for Emergency Room visits, unlike private payers, which could skew measure results.

> *Yes, these reports are really helpful and I think segregating it from Medicaid, Medicare population versus commercial populations is helpful because it's a different group of patients and they have different challenges.* (Practice 7)

Two respondents suggested having data in the CHIPRA Practice Report broken down even further by specific insurer and coverage type (e.g. Harvard Pilgrim vs. Tufts).

> *…some practices have an awful lot of Harvard, and some have more Blue Cross Blue Shield, and some have more of Tufts. Just to see that. It's interesting to see, from a paying standpoint, who's paying what and who's monitoring these things, and [the] supports from that health insurance to do that.* (Practice 2)

On the other hand, some respondents indicated that the breakdown of rates by payer type was not useful because clinical care was the same regardless of insurance status. One interviewee noted that insurance status is not known or considered by providers at the time of treatment.

> *What I find for our practice is we don't look at things by insurance. So it's not like we're doing extra for Blue Cross patients…If we're going [to] do it, we're going [to] do it across the board.* (Practice 8)

Finally, a few interviewees thought the report would be more useful if individual patient-level and provider-level information was also available. Patient-level data would allow providers to tailor interventions to specific patients while provide-level data would allow practices to identify low- and high-performing providers and target interventions accordingly.

> *For example, if it tells me that appropriate testing for sore throats, if there was one or two patients, it'd be nice to know which ones and where we failed. We'd look back and see how come that didn't work out.* (Practice 7)

> *…let's say that our measure with developmental screening. It's real low. It'd be nice to know whether it was low across the board for all of our providers or just certain providers that weren't doing it.* (Practice 3)

Reporting and Dissemination: When asked about their preferred delivery method for the report, about half of the interviewees indicated that an emailed PDF version was sufficient. They liked that it could easily be printed and brought to meetings for discussion. They also liked that they could quickly forward the document to other members of their team for review.

> *If I got [the report] by email, what I'd do is I'd print it out, and I'd bring it [to staff] at our meetings and say, "Okay, this is where we're at. The measures of well visits. This is where we're falling." That kind of thing. As a practice, we go over it also as a whole.* (Practice 1)

While some saw online delivery methods that require a username and password as a deterrent, other respondents expressed an interest in receiving the report through a web-based platform. Their interests lie in the ability to receive the data more frequently and to drill down into the information by provider and/or patient. An online version would also allow providers to view only the sections that are of interest to them.

> *I'd love it online. I'd love to be able to get it really frequently, so we're getting it quarterly instead of looking back three years or four years ago.* (Practice 4)

Additionally, the CHIPRA Practice Report was viewed by some as less useful since the data reported was four years old. A few respondents suggested that in order for the report to be truly useful, the data would need to be current. One respondent suggested the data be no more than six to twelve months old.

> *I have memories of our old [Health Plan] reports that we were getting…where it was so delayed that there was really very little we could do with the data that we were given.*

Going forth, if this was a report that would be helpful for providers, it would really have to cut down on the time lag between data availability and reporting. (Practice 3)

B. CHIPRA Quality Measures

In order to assess whether practices found the information in the CHIPRA Practice Report relevant and actionable, interviewees were asked specific questions about the reported quality measures. Interviewees were asked to identify the measures that were most useful and least useful to their practice; as well as any omitted measures they believed should be included in the report. The CHIPRA Practice Report provided performance scores on the measures listed below. Both MassHealth- and commercially-insured children are included in the report, except where otherwise noted. Fewer measures were included for commercially-insured children, since for Cycle 1 there was limited commercial data available.

Measures

Access and Availability of Care

- Children and Adolescents Access to Primary Care Practitioners

Preventive Care and Health Promotion

- Developmental Screening in the First Three Years of Life
- Percentage of Eligible Children Who Received Preventive Dental Services (MassHealth only)
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Well-Care Visits for Adolescents Ages 12 to 21

Behavioral Health Monitoring

- Follow-Up after Hospitalization for Mental Illness
- Follow-Up Care for Children Prescribed ADHD Medication

Management of Acute Conditions

- Ambulatory Care: Emergency Department Visits (MassHealth only)
- Percentage of Eligible Children Who Received Dental Treatment Services (MassHealth only)

Management of Chronic Conditions

- Annual Pediatric Hemoglobin (HbA1c) Testing (MassHealth only)
- Annual Percentage of Asthma Patients with One or More Asthma-Related
- Emergency Room Visit(s) (MassHealth only)

Appropriate Testing

- Appropriate Testing for Children with Pharyngitis
- Chlamydia Screening

Most Useful Measures: Several interviewees believed all the measures were useful to their practice. One interviewee noted that this was evidenced by the fact that most practices had already been collecting data on the measures for some time.

> *…I think they're all useful. Because, as I said, we're doing these things without your [CHIPRA Practice] report. Obviously [the measures] must be useful if every practice that I know of is…trying to make sure that we're meeting these measures, or at least if we're not meeting the measures, understand why they're important…* (Practice 2)

Nonetheless, there were some measures that interviewees identified as more useful than others. Measures that were particularly useful to interviewees included well-child visits, behavioral health monitoring (follow-up after hospitalization for a mental illness within 7 and 30 days of discharge and follow-up of care of children prescribed ADHD medications), dental care, and emergency department (ED) utilization. Several interviewees favored the preventive care measures. One interviewee noted that the measures on well-child visits demonstrated how well their practice was able to engage and monitor patients.

> *I think these kinds of reports are helpful, particularly Medicaid has been doing these reports year in and year out and it's nice to hear back from them that I'm an outlier [for] well-child checkups. Because it just tells me that as a pediatrician, they trust me and they come back to me and they're coming in for their physicals at a very high rate compared to my peers. It's good information…* (Practice 7)

Interviewees also reported that it was helpful to see the percentage of well-child visits by different age groups as this allowed them to identify gaps and focus their quality improvement efforts on certain populations.

> *The checkups are great, especially the age of five and up…because sometimes patients when they turn five they think they should disappear out of here. They should disappear at the doctor's office. Doing this, I can see how much we need the measurement of well checkups after five years old, five and up. Most of our patients on our practice site report they just disappear after five. They don't think they should be doing a checkup every year…The preventative care it's very useful.* (Practice 10)

For example, one interviewee noticed that their practice's rates of adolescent well-care visits were low and planned to use this information to schedule visits during the summer months when these patients might be more likely to attend.

> *One of the things I noticed when I looked through [the CHIPRA report], it gave me a real view of what areas that we very quickly needed to begin to look at…so I'm looking at one [measure] right now, the well child, this is adolescents…Definitely low…so I'd have that*

> *number, that age group, [sent] over to pediatrics to make calls to start schedules… because we know with that population how to get them in. If we start now especially with the summer months coming, we have a higher potential to get that group, that age group in. They may need school physicals…* (Practice 3)

Several interviewees identified measures that focus on care outside of the primary care setting as particularly useful, including measures on behavioral health, ED visits, and dental care. These measures provide data to practices that they typically would not be able to capture or access otherwise.

> *I think the dental visits is helpful, because we don't know that. I mean, a lot of these measures we're starting to get actually real-time now…A lot of the stuff actually comes out of our EHR software now. We can't capture dental visits, because that depends on who our patients go to see for their dental provider. That actually is interesting, because we don't have that data available to us.* (Practice 3)

Additionally, these measures help practices to assess whether they are effectively coordinating care. As one interviewee explained, the primary care provider is often unaware of the care their patients receive outside of their practice unless they are informed by the patient or external provider.

> *…there's not a lot of data that's shared with the behavioral health [providers]. Sometimes even for a follow-up after hospitalization we may not even know the child was hospitalized. Because you don't get a lot of the behavioral health records, it's hard to follow up sometimes. It could be three weeks/a month down the road when a parent calls and says, "Oh yeah, we were hospitalized—my child was hospitalized."* (Practice 1)

Behavioral health monitoring can be especially challenging for primary care practices since access and availability of these services can be limited. One practice described using this information to improve access to care, for example, by building relationships with other providers.

> *Well, behavioral health probably, because it's a challenge. Because there's so few providers of behavioral health…and everybody is trying to get to the same people. The hospitals have them for a while and then they move on to something else. This is the kind of issues that we're having. I'm sure out there [there is] not a lot of pediatric psychiatrists or psychologists. Probably more psychologists, but we're having a hard time trying to find people to take care of them. The older kids are hard to follow, so any report that you have would be helpful.* (Practice 2)

> *…when I'm looking at one of the measures, and that is around behavioral health monitoring, it shows us that we really do have some challenges in that area. How I*

> *would translate that is we would as a practice begin to look at…what availability do we have to get these patients to a provider? What do we need to be tuned in? Do we as a practice need to reach out and have relationships, which we do and we are continuing to do and building on, with providers so we can get our patients in to be seen? That kind of information would be something that I would benefit from.* (Practice 5).

Interviewees found the ED utilization measure useful because it can serve as both an indicator of access to care and service utilization. For example, one interviewee explained that high rates of ED use could suggest that the practice needs to open at different hours.

> *One measure that is somewhat interesting is the ambulatory care for emergency department visits as they are related to MassHealth only. That's information that really can be beneficial to us because it indicates to us what time frames do we need to be available to the patient. Are these visits to the ER really something that could've been managed by the pediatrician? Was it at a time when we were open as a practice and the patient didn't come to us with something that they should've? There's an educational opportunity on both sides for that.* (Practice 5)

Although the ED measure is generally used to assess overuse of the ED, low ED rates in certain populations could also indicate a greater need for culturally appropriate care. One interviewee explained that patients in his practice are more likely to underutilize the ED due to cultural barriers such as language.

> *I think the ED visits is interesting. I think the information—typically I think when we look at ED visits as a measure of quality—a quality measure, it's really whether there's overuse. I think in our population, where our patients are very linguistically limited, they actually feel real intimidated going to the emergency department…my worry is actually that they're underutilizing it, because they're afraid of not being understood and not being able to communicate when they go to an emergency department, that [providers in the ED] can't speak their language.* (Practice 3)

Least Useful Measures: Interviewees were also asked to identify the least useful measures in the CHIPRA Practice Report. Responses varied, suggesting that the usefulness of a measure is subjective and could be dependent on the practice's patient population. For example, one interviewee identified rates of pediatric hemoglobin testing as less useful since there were few diabetic patients in their practice and thus it may not be an accurate indicator of overall practice performance.

> *I think that's similar to the A1c measure. It's such a small population for kids, I don't know how useful that is, because for a practice you typically only have a few diabetics. I'm not sure how valuable that is in looking at care.* (Practice 3)

Interviewees identified measures that were based on claims data as less useful since this data can be inaccurate and is often missing information.

> *… for the well children checkups, when you're dealing with 50 patients, 40 patients, 70 patients, it's helpful. When you're dealing with two or three patients—for example, appropriate testing for children with pharyngitis, in this report there was one. I would say the reality, there was probably, of those patients that had strep testing in that population, there would be probably 200…Coding or the data analysis didn't pick it up, used the wrong code, or they didn't have the right amount of codes.* (Practice 7)

> *Because the data comes from claims data…things like the developmental screening, for instance, are problematic because it's based on paid claims. That's not always the most accurate way to do it...especially if we're talking about within the last quarter or even six months, it's going to have some sort of error rate…We may have initial denials, or a part of the claim may not get paid for some reason, or their managed care organization eligibility changes after we've submitted the claim…* (Practice 4)

Other issues with measure specifications, such as restrictive timeframes, also limited the usefulness of certain measures. For example, rates for well child visits may be low due to patients scheduling visits outside the measure timeframe.

> *One of the things that always—I don't know if this has anything to do with this report, but I always find it very frustrating that most people we get in for about 8 visits before their 15 months. The fact that there are some people who skip them and then if they come in for their 15 month like a day late, it's not counted, which seems really silly.* (Practice 6)

Furthermore, wide age ranges for the well child measures made it difficult to determine which subpopulations were contributing to the low rates for one practice. For example, data for individuals aged 18 to 21 years could be contributing to low rates for the adolescent well care measure since this population may no longer be living at home and could be receiving school-based services.

> *For example, when they look at access to health for ages—what is it—12 to 21. That's a huge group. It made it hard to really look at how—which age group was in that. Is it the tweens? Is it the teens? Is it the kids? I mean, is it almost the people who aren't really kids, like the 18 to 21 year olds? Right. I think that huge age gap makes it really hard to digest the information. The initial reaction is, "Oh, those must be the kids that went to college and that's why they're not coming in for the check-ups anymore."* (Practice 3)

Interviewees also reported some quality measures as not being consistent with clinical practice. For instance, the dental measure recommends that children begin seeing a dentist at the age of one, however, it is often difficult to find dentists willing to comply with this recommendation. Similarly, with regard to the chlamydia screening measure, there is some debate as to whether screening is effective.

> *When I was looking at the dental visits measure, I—that was another one where I felt like the age range was a little bit too big. Also, maybe, also a little unrealistic, even though those are the recommendations for children. Typically we advise parents to take their children to see a pediatric dentist after the age of one, but there's almost no pediatric dentists that will see patients at age one.* (Practice 3)

> *The other thing that's not helpful to us, and this is a clinical issue, is the chlamydia screening in women aged 16 to 20. That's actually somewhat controversial, that measure. It's a fairly expensive test to run. We've been running it universally in all of our teenagers at their well visits. Sometimes you can get the kids to provide the sample; other times, they're suspicious that you're trying to do drug testing, and they won't give it to you. I'm not sure that—our providers here in the office have had an ongoing discussion about whether it's a measure that really actually catches —whether it's worthwhile…studies have been showing that it's probably less effective than initially thought. That's just a controversial measure.* (Practice 4)

Finally, one interviewee did not see measures that assess for "standards of care," such as appropriate testing for pharyngitis, as a good measure of quality since most providers would receive high rates. Rather, a low rate for these measures would most likely indicate an issue with coding or documentation.

> *For example, most pediatricians on, let's say, a measure of strep testing or appropriate testing for pharyngitis and upper respiratory, most physicians do exactly what they're supposed to. The reason the report would be abnormal is a coding issue. Not coding it, because everybody does a strep test for strep. It should be 100 percent all the time. So if you're 93 percent or 92 percent or 80 percent, then it's a coding issue because in my practice, everybody with sore throats who gets an antibiotic gets a strep test, all the time, all the time. So if that number's out of whack, what it tells me, it tells me nothing about quality. It tells me that I have a coding problem or an error problem or a data collection problem.* (Practice 7)

<u>Additional Measures to Report:</u> Several interviewees suggested that additional measures be added to the report. Suggested measures included data on specialty and non-acute care that is provided outside the practice site since this information could be used to improve coordination of care and management of chronic conditions.

> *…a lot of our patients are using these Minute Clinics and walk-in centers. I'm very interested in how we follow these people after these clinics have given them antibiotics that we wouldn't necessarily have done. Or they're giving them immunizations that we hadn't—that we wouldn't know because the parents, they didn't say to the parents, now make sure you call your primary care and tell them you had this….*(Practice 2)

> *…we would really like to know, in addition to ED rates, where our children are going to see specialists and perhaps what the cost of that is…Certainly, if we really talk about management of chronic conditions, what we really want to do is make sure your primary care office is managing chronic conditions without having to send [the patient] to specialists unnecessarily…If you're following ED rates, why not follow specialist visits as well?* (Practice 4)

Interviewees also requested more information on childhood immunizations, listed out separately, and dental care since these are important indicators of future health.

> *Certainly whether or not there has been a dental visit, but sealants as well would be a good measure. Preventive dentistry in this age category is enormously important and a predictor of future health.* (Practice 9)

Other measures of interest included health outcome measures which are less prevalent and difficult to measure in children. One possible outcome measure is hospitalizations for asthma, which is absent from the CHIPRA Practice Report but could be added to supplement process (e.g. asthma follow-up care) and other adverse outcome measures (e.g., asthma-related ED visits).

> *As long as the pediatric community is still searching for really good ways to actually measure outcomes in children, especially over long periods of time, this is what we have...We would love to see an expansion of these asthma follow-up rates. Is it making a difference in asthma hospitalizations? If kids are on controllers, does that make a difference? If a certain kid goes to the ED more often, are they less healthy? How do we determine that? I think the pediatric community as a whole is really struggling with all that stuff, and in the meantime, also trying to cut costs, which is the other thing.* (Practice 4)

Two interviewees recommended adding other measures relating to socioeconomic status and cultural competence. One interviewee thought it would be helpful to have information on the percentage of children eligible to receive reduced and free lunch in their practice since it could be used as indicator of good nutrition. Another interviewee was concerned that their patient

population was underutilizing health care services and suggested adding measures to assess access to care for populations with language limitations.

> *I don't know how possible this is to get from this data, but whether or not someone is enrolled in the school lunch program, like how many of your kids are enrolled in it across these categories…because it would tell me that if a lot of our Free Care patients or a lot of our MassHealth patients were not enrolled in the school lunch program that maybe there was some under-nutrition and it would be an indicator of a food desert of some kind.* (Practice 9)

Below is a summary of the measures recommended by interviewees.

Access and Availability of Care:

- Measure to evaluate access to care for patients with language limitations;

Care Coordination:

- Non-urgent care use (e.g. Minute clinics) and follow-up;

Health Outcomes:

- Asthma hospitalizations;

Management of Chronic Conditions:

- Specialty care and associated costs;
- Asthma medication use;

Preventive Care and Health Promotion:

- Rates of flu vaccinations;
- Rates of childhood immunizations listed separately;
- Rates of children receiving dental sealants;

Other:

- Rates of children receiving free or reduced lunch.

C. How Providers Would Use the Report

Overall, practices found the CHIPRA Practice Report useful and all of the interviewees said that they would want to receive such a report in the future. Most practices would use the report for quality improvement purposes. Interviewees reported that the information in the report helped them to identify gaps and outliers in specific quality measures and to focus their quality improvement efforts.

> *I think it was helpful to see where some of the data showed some outliers and it made it—it made me think about, "Oh, why is that happening?" I think in that sense those*

> *type of messages got across. For example, we have these very low scores for our well child checks for adolescents in our commercial payers versus our MassHealth payers. I just had to think a little bit about why that was happening or why that data exists.* (Practice 3)

> *I think it helps us identify areas that we may not be looking at that are important. For example with the whole ADHD meds, we thought we were meeting the rules. We're asking kids to come back after a month. That's the rule. Come back in 30 days. Seeing that percentage made us say, "Stop. What's wrong?" We're doing what we think—we think we're doing this right, but we're clearly not because our percentages are reflecting that. I think using some of those things that [is] maybe off our radar. We're so focused on well visits and getting their immunizations done and different things that sometimes we forget about the other stuff.* (Practice 8)

Although the CHIPRA Practice Report only provides data at the practice-level, some practices could use information from the report to also run patient registry reports to monitor and follow-up with patients.

> *If our scores were low in one area, we could run a registry report to reach out to the patient to get them in for well visits. (Practice 1)*

> *Well, we certainly need it to follow kids and make sure that they have the annual physicals, as they get harder and harder every year. We have devised a report here in-house so we can see if somebody missed, not coming. We just actually started working on that for these 12 to 18 or 21 age group, trying to find the outliers of having shown up every year, identifying them, and then calling them.* (Practice 2)

Measure results could be used to develop workflow changes, including changes to billing and documentation. For example, a low score may indicate improper documentation rather than a deficiency in care. Providers may not receive credit for care provision if they fail to use the proper billing code or do not document the service in the patient's medical record.

> *I think the big thing is looking at protocols. Really it's looking at these to see are we following through. It's all about closing the loop…For us, for example, the behavioral health monitoring, the discharges, is that a policy we have? How are staff going to remember to do that? What's the trigger? Is it getting that scanned document note from the hospitalization? Then does that scanner person call and schedule the follow-up? Getting flows around these things that we never had before is what we're going to use it for. Yeah, so that's a big one.* (Practice 8)

> *…because this data is all collected from billing data. It's not collected in real time. For example, every patient with a sore throat gets a strep test. Everybody with a cold*

> *doesn't go on an antibiotic. So if the numbers are out of whack, then there's a coding problem or a way the bills are going out and the data's collected.* (Practice 7)

Practices could also use the report to track and evaluate their initiatives over time. Information from the CHIPRA Practice Report could also be used to validate and compare performance scores with other data sources.

> *As I said, these reports are useful because it helps us to focus on what we want to work on. We are constantly working on improving the practice and the access to care for our patients. It always helps to help focus on it, but then it also really helps to measure over time whether the resources we're putting from our practice into a particular initiative are actually working. Most practices are sort of always trying to think of how we can do things better, but it's really difficult to figure out whether—if I hire another person to coordinate the follow-up care for ED or asthma follow-up rates, etc., I want to make sure that that money the practice is spending is well worthwhile, that's it making a difference to our kids.* (Practice 4)

> *I think if I was a quality improvement person I would look at it to see if it jives with what I'm seeing, what I'm getting out of our EHR, and maybe what I'm getting from maybe our different payers to see if it's consistent. If it's not consistent, then I would take a look at it to see why. What's different?* (Practice 3)

3. Discussion

A. Key Findings and Recommendations

Practices participating in this study were accustomed to receiving quality reports from other payers but favored the CHIPRA Practice Report for its design and format, which made it easy to read and understand. Unlike other quality reports, the CHIPRA Practice Report provided practices with data for both their MassHealth and commercially-insured patients. Thus practices were given a fuller view of their performance for providing quality care across their patient population. Additionally, combining results across payers into a single report could reduce duplication and prevent report fatigue. The inclusion of standard and nationally-recognized measures may have increased acceptability of the report since most interviewees were already familiar with the measures. Additionally, the CHIPRA Practice Report included a clinical impact section which could help practices less familiar with quality measurement understand the importance of reporting the data.

Some practices may place more value on information that is centered on care outside the primary care setting since they may not have access to this data. Should the CHIPRA Practice Report be replicated in the future, consideration could be given to including more measures that fill this gap in information for primary care providers, especially as more attention is placed on

providing patient-centered and coordinated care. Measures on preventative care, such as childhood immunizations, should also be considered, as they are of high-value to primary care practices.

Practices identified a variety of uses for the CHIPRA Practice Report, including quality improvement, population management, performance monitoring, and data validation. The CHIPRA Practice Report could be further improved by providing practices with more current data and making it available through different modalities (online and paper-based). The report would be more actionable for practices with timely data and an online interface could give practices more flexibility in navigating the report and drilling down on specific measures. Furthermore, measure results may be more reliable if providers are able to validate the data in the report before results are published in order to identify inaccurate or missing data.

B. Limitations

It should be noted that the findings from this report are from a small sample of practices and are not representative of all practices across Massachusetts. Furthermore, the views may be biased since some practices included within this sample had previous engagement with the CHIPRA Demonstration as comparison sites. Several of the practices indicated that they already received or collected data on the measures included in the CHIPRA Practice Report. Therefore, it would be worth exploring whether practices that are less familiar with quality measurement and improvement would find such a report valuable and useful.

4. Conclusion

Recommendations from this report can be used to improve quality measurement and reporting to pediatric practices in Massachusetts. The findings suggest that practices would be receptive to receiving the CHIPRA Practice Report in the future. However, consideration will need to be given to the feasibility and sustainability of collecting and producing practice-level reporting, especially across payers, in order to minimize duplication and provide meaningful data to practices. Qualitative interviews were conducted with CHIPRA project staff on the feasibility for collecting data and calculating rates for the CHIPRA core measures at the practice-level. Lessons learned are presented in a separate report.

Appendix A: Recruitment Email

Dear XX,

I am writing to request your participation in a short interview about a report (see attachment) developed for a pilot project known as the Massachusetts' Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Project. The project is funded by the Centers for Medicare and Medicaid Services (CMS) and is led by MassHealth and its partners: Children's Hospital Boston, Massachusetts Health Quality Partners, National Initiative for Children's Healthcare Quality, and UMASS Medical School. One of the objectives of this 5-year pilot project is to develop a report for providers on children's healthcare quality. The goal of the CHIPRA Report is to share comparative data with practices on their performance on a subset of quality measures from the CHIPRA Core Set of Children's Health Care Quality Measures, issued by CMS and the Agency for Healthcare Research and Quality (AHRQ). The CHIPRA Report provides practice-level results for MassHealth and commercially-insured patients in your practice compared to statewide performance by provider peers.

UMASS Medical School is leading the evaluation of the CHIPRA demonstration project. An important part of the CHIPRA grant project is to obtain practice feedback on the CHIPRA Report and the measures being collected; we are hoping to interview 10 practices in all. If you agree to participate, we will schedule a brief 30-40 minute interview with you to get your feedback on the usefulness and relevance of the information in your practice's report (see attachment). Your feedback will help to inform how pediatric quality measures are selected and reported in the future.

Interviews would be scheduled at your convenience and can be done in person or over the phone. I'm happy to answer any questions or concerns you may have; you may contact me by email or via phone at XXX-XXX-XXXX. Please let me know of your interest and availability for an interview.

Thank you.

Appendix B: Interview Guide

Introduction:

Thank you for agreeing to talk to us about your practice's CHIPRA Report. Hopefully, you have had an opportunity to review it. One of the objectives of this project is to obtain providers' feedback on the content and format of the report. Specifically, we are interested in learning whether providers find the report readable and understandable; and whether reporting measure results by insurance status (i.e. MassHealth vs. privately insured patients), and the types of care being measured are useful and relevant to your practice. In addition to your practice, we are also gathering input from, staff at 9 other practices.

Everything you share with us will be completely confidential. General themes and quotes will be reported across all the interviews we conduct without containing any identifying information that can be attributed to you, or any other individual practice.

We would like to record the interview. The recording will be destroyed after we have completed the evaluation. Only members of the UMass evaluation team, which is working on gathering and synthesizing the information gathered from you and the other practices, will have access to the recordings which will be stored on a password protected computer.

Do you have any concerns with this level of confidentiality? Do you agree to being recorded?

Do you have any questions before we begin?

Let's get started

Questions

Today we're going to be asking you questions about your practice's CHIPRA Report. As you may recall, the CHIPRA Report was developed as part of a pilot project and is an example of a type of report that might be made widely available to providers in the future. We recognize that the data in the report is from 2010, so when answering our questions we would like you to focus more on the content and the format of the report.

1) What do you find useful about this report? What is not useful? Why?

2) How might you use the information in this report for your practice?
    a. Quality improvement efforts ,
    b. Practice management,
    c. Other

3) This report provides data on a select number of measures.
    a. What measures did you find most useful? Please explain.
    b. What measures did you find least useful? Please explain.
    c. What other measures do you feel should be included in the report?

4) **For practices whose reports included measures reported by payer** - In the report, your practice's results are measured and reported separately for your commercial and MassHealth patients. Is it helpful for you to see your practice's results broken out in this way? Why or why not?

   For practices whose reports DO NOT include measures reported by payer – Would it have been helpful to see your practice's results measured and reported separately for your commercial and MassHealth patients, why or why not?

5) What do you think overall about how information is presented in this report?
   a. What do you like best? Please explain.
   b. What do you like least? Please explain.

6) Would you like to receive a report like this in the future? Why or why not?

Everything that you have shared with us today has been very helpful. Is there anything else you'd like to tell us?