

Nine States' Use of Collaboratives to Improve Children's Health Care Quality in Medicaid and CHIP

Kelly J. Devers, PhD; Leslie Foster, MPA; Cindy Brach, MPP

From the Urban Institute's Health Policy Center, Washington, DC (Dr Devers); Mathematica Policy Research Inc., Oakland, Calif (Ms Foster); and Agency for Healthcare Research and Quality, Rockville, MD (Ms Brach)

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Address correspondence to Kelly J. Devers, PhD, 2100 M St NW, Washington, DC 20037 (e-mail: kdevers@urban.org).

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ABSTRACT

We examine quality improvement (QI) collaboratives underway in 9 states participating in the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant Program. A total of 147 diverse, child-serving practices were participating in the collaboratives. We conducted 256 semistructured interviews with key stakeholders from March to August 2012—2 years into the 5-year demonstration projects—and analyzed states' grant applications, operating plans, and progress reports. The collaboratives have multiple complex aims. In addition to developing patient-centered medical home (PCMH) capability, some states use collaboratives to familiarize practices with CMS's Initial Core Set of Children's Health Care Quality Measures, practice-level quality measurement, and improving QI knowledge and skills. The duration of the collaboratives is longer than other well-known collaborative models. Collaboratives also vary in their methods for targeting areas for improvement and strategies for motivating practice recruitment and engagement. States also vary with respect to the other strategies they use to support QI and PCMH development. All states supplement the collaboratives with practice facilitation; the majority utilized practice-level parent engagement, but only 4 used workforce augmentation (ie, providing care coordinators and QI specialists). Practice staff highly valued aspects of the collaboratives and supplemental strategies, including the opportunity to work with experts and other child-serving practices; states' efforts

to provide stipends and align demonstration efforts with other professional requirements or programs; receipt of relevant, customized QI materials; opportunities to learn how care coordinators or QI specialists might work in their practice without the risk of hiring them; and satisfaction from learning more about quality measures, QI concepts and techniques, critical medical home components, and how to identify PCMH capacity and performance gaps. However, practice staff also reported a variety of challenges, including difficulty learning from other practices that have very different preexisting QI and PCMH capacity and patient populations, or that are working on different topic areas and measures; a sometimes overwhelming amount of materials and ideas covered during in-person meetings; difficulty keeping up with Webinars, calls, and Web sites/blogs; and trouble motivating and sharing information with other practice staff not attending collaborative activities. As the demonstration projects continue, states and the national evaluation team will learn more about how best to use collaboratives and complementary strategies to support child-serving practices in QI and PCMH development. States will also search for ways to sustain and spread these activities after the demonstration ends, if they prove effective.

KEYWORDS: collaborative; Medicaid/CHIP; patient-centered medical home; primary care; quality improvement

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WHAT'S NEW

Quality improvement collaboratives in 9 states have ambitious aims, including helping Medicaid- and CHIP-serving practices become patient-centered medical homes, learn new quality improvement strategies and improve performance on key quality measures. All 9 collaboratives use a variety of supplementary strategies.

EVIDENCE FROM THE past decade shows that the quality of health care delivered to children in the United States is in urgent need of improvement. Shortcomings include deficits in the receipt of recommended care for preventive services, acute care services, and chronic care services¹; fragmentation of care for children who see

multiple health care providers²; and lack of continuity in the primary care clinicians whom children see during early childhood.³ Evidence also indicates that children with public insurance fare worse than privately insured children on many aspects of quality.^{3,4} The gaps in children's care quality are similar to those facing the US population overall, as described in the Institute of Medicine's *Crossing the Quality Chasm*.⁵

The Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant Program, authorized in 2009, is a \$100 million, 5-year effort to improve care quality for children in Medicaid and CHIP. The federal program, administered by the Centers for Medicare and Medicaid Services (CMS), funds 18 states working alone or with 1 or 2 partner states, to implement promising approaches to quality improvement

(QI) and to develop or strengthen medical home capacity. Many of the participating states are involving practices in quality improvement collaboratives as one strategy to achieve some of their objectives.

QI collaboratives for health care organizations date back to the 1980s and can generally be defined as an organized, multifaceted approach that includes 5 features: 1) a specific topic, typically one with large variations or gaps between current and best practice; 2) clinical and QI experts to provide ideas and support for improvement; 3) a critical mass of multiprofessional teams from multiple sites willing to improve and share ideas; 4) a collaborative process involving a series of structured activities (eg, in-person meetings, Webinars, conference calls, e-mail mailing lists) in a given time frame to advance improvement, exchange ideas, and share experiences; and 5) a model for improvement that focuses on setting clear and measurable targets, collecting data, and testing changes on a small scale to advance reinvention and learning by doing.⁶ The Institute for Healthcare Improvement (IHI) Breakthrough Collaborative Series is one of the best known and most extensively evaluated collaborative models.^{6,7} Several other state-based QI projects, including the Assuring Better Child Health and Development (ABCD) Program, share the IHI's general philosophy and collaborative approach, if not its operational parameters, such as the number and frequency of meetings or the duration of collaboration.^{7,8}

The primary rationale for QI collaboratives is that provider organizations working together are more likely to generate and sustain quality gains because of the opportunity to learn from experts and each other, in part through positive peer pressure. Research about the effectiveness of QI collaboratives and their individual elements is inconclusive.⁹ Some collaboratives, however, have achieved at least modest positive results, including several in pediatrics.¹⁰ Consequently, the CHIPRA quality demonstration states expect that QI collaboratives in combination with supplementary strategies will provide practices with tools, expert advice, and peer support, as well as with the motivation needed to succeed.

Here we examine the early experiences of 9 demonstration states using QI collaboratives to improve care quality at the practice level. We address 3 research questions: 1) What collaborative approaches have states chosen and how are they implementing those approaches to date? 2) What additional strategies are states using to facilitate QI and practice transformation? 3) What do demonstration staff, practice staff, and other stakeholders cite as the strengths and weaknesses of these collaborative and additional QI approaches?

METHODS

The data used for this study consisted primarily of 256 semistructured interviews conducted from March to August 2012 with stakeholders in 9 states that had made substantial progress in implementing practice-level QI collaboratives. Respondent characteristics are summarized in Table 1. In the 9 states, a total of 147 diverse, child-serving practices are participating in QI collaboratives. At the time of the interviews, these states were about 2 years into their 5-year CHIPRA quality demonstration projects.

In each state, we selected a purposive sample of interview respondents who could provide rich firsthand information about states' demonstration projects.¹¹⁻¹³ Respondents included staff directly involved in the design and implementation of states' demonstration projects; staff and contractors specifically involved in states' QI activities; clinical and administrative staff at participating practices; and representatives of children's advocacy organizations, child-serving state agencies, state chapters of the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and associations of federally qualified health centers.

Except for a small number of telephone interviews, interviews were conducted during site visits to demonstration states. One interviewer and one note taker participated in each interview. Interviews were audio-recorded with the respondents' express consent.

To prepare interview data for analysis, researchers cleaned notes (using audio recordings to fill in gaps) and uploaded them into NVivo software (version 9.2),

Table 1. Characteristics of Respondents: State and Respondent Type

State	State Staff*	Professional Association Staff	Practice Facilitator/ QI Coach†	Participating Practice Staff‡	Other Stakeholder§	Total
Florida	9		1	13	3	26
Illinois	8	2	1	8	11	30
Maine	10		1	2	5	18
Massachusetts	5	1	2	12	11	30
North Carolina	4	2	2	11	9	28
Oregon	11	1	1	8	4	25
South Carolina	7	1	1	16	8	33
Utah	9	1	4	12	12	39
West Virginia	8		1	16	2	27
Total	71	8	14	98	65	256

QI = quality improvement.

*Includes consultants hired by the state for this demonstration.

†Some QI coaches are also state staff; they are counted only in the Practice Facilitator/QI Coach category.

‡Includes physicians, medical assistants, nurse practitioners, physician assistants, administrative staff, and internal care coordinators.

§Includes patient advocates, managed care organization representatives, and academics.

a qualitative data management and analysis tool.¹⁴ Researchers coded the interview data using a scheme developed from general frameworks for qualitative health services research and anticipated areas of inquiry.^{12,15}

During analysis, we used NVivo queries to retrieve coded data (ie, interview text on specific topics) and to read and review interview sections, and we used other well-established techniques to identify key patterns and themes.^{12,13} The analysis focused on comparing and contrasting QI collaborative strategies, their perceived strengths and weaknesses, and lessons learned within and between states and respondent types.

Steps taken to ensure the quality of data collection and analysis included the following: provision of training for interviewers, note takers, and coders; review of notes for completeness and accuracy; and review of coded data for intercoder reliability. Coding reliability was assessed using NVivo's Kappa Coefficient calculation tool, and excellent agreement was achieved on the majority of codes.¹⁶ The few codes that had less than excellent agreement were discussed among all coders to clarify their intended usage. Additionally, coders were encouraged to use multiple codes where appropriate, to ensure that a given segment of text would be included in relevant queries.

Analysis of the interview data was complemented by the review of states' grant applications, final operating plans, and progress reports to the CMS.

The institutional review boards of both Mathematica Policy Research and the Urban Institute, organizations contracted by the Agency for Healthcare Research and Quality to evaluate the CHIPRA quality demonstration grant program, approved this research.

RESULTS

STATES' APPROACHES TO QI COLLABORATIVES

The QI collaboratives designed by the CHIPRA quality demonstration states differed from some other well-known models⁶ in 3 key elements: complexity of the aims of the collaboratives, duration of the collaborative as a whole, and intensity of collaborative activities, including the frequency and duration of in-person sessions. States' collaboratives more or less conformed to other model elements, including leadership by clinical and/or QI experts, types of activities, and participation of multidisciplinary teams. Still, notable differences and similarities exist among states (Table 2).

TOPICS AND AIMS

QI collaboratives typically focus on a single specified topic. In contrast, the QI collaboratives being implemented as part of the CHIPRA quality demonstration projects typically have multiple, complex aims.

All 9 of the QI collaboratives aim to help practices to become, or to improve their standing as, patient-centered medical homes (PCMH). Transforming to the PCMH model—which entails delivering comprehensive patient-centered coordinated care—involves major shifts in the

design and delivery of health care. QI collaboratives provide training on PCMH concepts and specific practice capabilities captured in PCMH assessment or recognition tools, particularly the Medical Home Index (MHI) and the NCQA's PCMH 2011 tool.^{17,18} They may also conduct medical home practice assessments and gap analyses, identifying where practices (individually and as a group) need to strengthen PCMH capacity and related care processes.

A second aim of a majority of the QI collaboratives is to familiarize practices with the 24 measures that constitute the CMS's Initial Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Initial Core Set) (released via State Health Official letter on February 14, 2011)¹⁹ to get practices' input on their utility for QI purposes. A related aim is to help practices collect standardized quality measure data at the practice level and to use them to identify areas for QI and monitor progress over time.²⁰

A majority of QI collaboratives are also providing general training on QI strategies and techniques, such as plan-do-study-act (PDSA) cycles. In PDSA cycles, practices learn how to plan an intervention to improve care quality, do that intervention, study its outcomes, and then act on the information by continuing or modifying the intervention.

DURATION

One of the QI collaboratives that is part of the CHIPRA quality demonstration will run for the entire length of the demonstration's implementation period, or 4 years; 5 will run for 2 to 3.5 years; and 3 will run for 1.5 years. The fairly long duration may in part be due to the wide range of aims and topics to be addressed and the desire to create significant delivery system changes that are sustained beyond the grant period.

LEADERSHIP

Another essential feature of QI collaboratives is their leadership by clinical and QI experts. Although leaders of all 9 QI collaboratives are respected organizations and/or clinicians, there was variation in the types of organizations running the QI collaborative (Table 2).

NUMBER, SELECTION, AND TYPE OF PARTICIPATING PRACTICES

A central element of QI collaboratives is getting a critical mass of different types of practice professionals—typically a lead physician, nurse or care manager, and office staff—to participate. Although all of the QI collaboratives in the CHIPRA quality demonstration were able to attract such teams, QI collaboratives varied in the number and types of practices participating, their criteria for inclusion in the demonstration, and the strategies (eg, stipends, members-only Web site/blog, and workforce augmentation) they used to motivate and support practice engagement.

The number of practices participating in each state's collaborative ranged from 8 (in Oregon) to 24 (in Maine),

Table 2. QI Collaborative Features in 9 States

Features of QI Collaborative	State								
	Florida	Illinois	Massachusetts	Maine	North Carolina	Oregon	South Carolina	Utah	West Virginia
No. of practices participating	20*	16†	13	24	26‡	8	18	12	10
Duration	1.5 y	1.5 y	2.5 y	2 y	2 y for each cohort	2 y	4 y	3.5 y§	1.5 y
Leadership	American Academy of Pediatrics (professional association)¶	American Academy of Pediatrics (professional association)¶	National Initiative for Children's Healthcare Quality (nonprofit)	Maine Quality Counts (regional collaborative)	North Carolina Community Care Network (CCNC)/North Carolina Center of Excellence for Integrated Care (public-private partnership)	Oregon Pediatric Improvement Network (public-private partnership); Oregon Rural Practice Research Network (university-based network)	South Carolina Dept of Health and Human Services; American Academy of Pediatrics (professional association)¶	Utah Pediatric Partnership to Improve Healthcare Quality (public-private partnership)	CSI Solutions (consultants)
Activities									
Frequency of in-person meetings (duration)	Semiannually (1–2 d)	Semiannually (1 d)	Semiannually (2 d)	Semiannually (2 d)	Semiannually (1 d)	Semiannually (1 d)	Semiannually (2.5 d)	Semiannually (1 d)	Once (1 d)
Frequency of conference calls/Webinars (duration)	Monthly (1 h)	Monthly (1 h)	Monthly (1 h)	Monthly (1 h)	Monthly (1 h)	Monthly (1.5 h)		Monthly (30 min)	Monthly (1 h)
E-mail mailing list	✓		✓			✓			
Members-only Web site/blog	✓		✓		✓	✓		✓	✓
Practices report on quality measures to collaborative	✓		✓	✓	✓			✓	✓
Aims and topics									
Initial Core Set measures	✓		✓	✓	✓		✓	✓	✓
QI strategies	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical home model of care	✓	✓	✓	✓	✓	✓	✓	✓	✓

QI = quality improvement. y = years. d = days. h = hours. min = minutes.

*Florida experienced attrition in its QI collaborative, resulting in 16 participating practices as of late 2012.

†Sixteen practices are participating in Illinois's QI Collaborative. An additional 35 practices are receiving other types of technical assistance aimed at helping them adopt the medical home model.

‡North Carolina is offering its QI collaborative to 2 separate cohorts. Twelve practices participated in the first cohort and 14 practices participated in the second cohort.

§Utah is offering a 3.5-year QI collaborative that is composed of four 9-month subcollaborative projects.

||South Carolina did not initially offer conference calls as part of their QI collaborative but planned to begin offering such calls in 2013.

¶The American Academy of Pediatrics' national headquarters provided leadership to Florida's collaborative, while state chapters of this organization provided leadership to the collaboratives in Illinois and South Carolina.

and included a wide range of practice types and sizes—pediatric and family practices, federally qualified health centers, teaching and nonteaching practices, urban and rural practices, and practices that were either owned by larger systems or that were independent.

ACTIVITIES

Many states employed similar kinds of collaborative activities, but they varied in the specific offerings, their intensity and nature, and the type of activities conducted between in-person sessions (eg, monthly Webinars or phone calls, blog posts, and e-mail mailing lists). For example, all but one state has semiannual in-person meetings, but there was variation in their duration (1 to 2.5 days).

QI collaboratives also varied with respect to the materials they selected (eg, either as is or modified in some way) or developed. For example, some states drew heavily on national AAP materials but then contracted with other state-based organizations (eg, medical schools) or individuals (eg, nationally or state-recognized experts) to modify them or create additional materials geared toward particular clinical quality areas targeted in their demonstration project. This variation has important potential implications because these materials are a major source of information about evidence-based medicine and practices, and they may be shared with practice staff not participating in collaborative activities.

A key feature of QI collaboratives is that they focus on setting clear and measurable targets, collecting data, and testing changes on a small scale to foster innovation, reinvention, and learning by doing. States, QI collaborative leaders, and practices utilized somewhat different approaches to identify areas for improvement. Some QI collaboratives specified a small set of areas and measures for improvement for practices to address at the same time. Other states let practices choose their own specific areas and measures for improvement. The thinking is that if a practice is already doing well in one area or on one quality measure, it is less productive for them to focus on it, even though others might learn from them. Letting practices choose measures also can increase buy-in and potentially the chances of success.

After recruiting, states used a number of strategies to motivate practice participation and engagement. Many states provided practices with a stipend to offset the costs of participation, in some cases tying stipends to specific collaborative activities. Several others aligned or intend to align QI collaborative activities with professional maintenance of certification, medical school residency accreditation requirements, or the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. Some states also offered practices discounts on the cost of NCQA’s medical home recognition tool or application fees.

OTHER STRATEGIES TO SUPPORT QI AND PCMH DEVELOPMENT

PRACTICE FACILITATION

All 9 states are supplementing collaborative activities with practice facilitation or coaching (Table 3). Practice facilitators use a range of QI approaches to build the

Table 3. Complementary QI Strategies

State	Practice Facilitation or Coaching	Workforce Augmentation	Parents Involved as Advisors to Practices
Florida	✓		✓
Illinois	✓		✓
Maine	✓*	✓†	✓
Massachusetts	✓		✓
North Carolina	✓	✓ (QI specialists)	
Oregon	✓		✓
South Carolina	✓‡		
Utah	✓	✓ (care coordinators)	✓
West Virginia	✓	✓ (care coordinators)	

QI = quality improvement.

*In Massachusetts, a portion of 1 existing staff member’s salary per practice is subsidized with CHIPRA quality demonstration funds in exchange for them serving as an in-house practice transformation facilitator.

†In Massachusetts, participating practices have been provided with a part-time care coordinator hired through the state’s Department of Public Health with non-CHIPRA Title V funds.

‡In South Carolina, providers can accompany the practice coach on site visits to other practices to learn what other practices are doing.

internal capacity of a practice to transform and improve patient outcomes over time.²¹

The nature and type of practice facilitation varies among the states. For example, the background and experience of the facilitator varies, as does the amount of time facilitators spend with practices, and whether facilitation is in person versus by phone. In Massachusetts, a trainer prepares a practice employee (typically a registered nurse, medical assistant, or office manager) to be an in-house practice transformation facilitator. This approach is designed to provide more immediate and ongoing assistance while reducing the cost, potentially improving sustainability and spread.

WORKFORCE AUGMENTATION

Three of the 9 states are also augmenting the practices’ workforce by funding and embedding care coordinators (Massachusetts, West Virginia, Utah) or QI specialists (North Carolina). These staff members are formally employed by the state itself or a state-subcontracted QI organization, but they work regularly at one or more practice sites, although practice staff may participate in their selection. Care coordinators help manage the care of children with special health care needs or at high risk of poor care quality, while the QI specialists assist with the collection of practice-level quality measure data. These staff may be new to a practice or new in the care coordinator role and thus receive additional training. In one state (Massachusetts), care coordinators employed by public health departments and funded from Title V funds are also working with, and in, practices.

FAMILY ENGAGEMENT

Finally, QI collaboratives often encourage practices to form patient and family advisory councils or partner with families to get direct input on ways to improve patients’

experience of care. (See Carman et al²² for a patient engagement framework, including direct care, organizational design and governance, and policy making.) Many feel strongly that this sort of involvement is of paramount importance, as a way of putting the patient in the patient-centered medical home model. Although states may collect and report patient-experience survey data (eg, Consumer Assessment of Healthcare Providers and Systems [CAHPS]) at the health plan level, they have not typically collected and reported such information at the practice level (eg, CAHPS Clinician and Group or CAHPS Clinician and Group PCMH).^{23,24}

PERCEIVED STRENGTHS AND WEAKNESSES OF QI COLLABORATIVES AND COMPLEMENTARY STRATEGIES

Overall, respondents reported several major strengths of QI collaboratives and other efforts to help support QI and PCMH development. The CHIPRA quality demonstration has benefited child-serving practices that may not have previously had the opportunity or capacity to participate in a quality demonstration of this magnitude and duration. Practice staff generally valued the following highly:

- The opportunity to work with national or state-level experts and other child-serving practices.
- States' efforts to provide stipends to defray participation costs and align CHIPRA quality demonstration efforts with other professional requirements or programs.
- Receiving relevant, customized QI materials.
- Opportunities to learn how care coordinators or QI specialists might work in their practice without the risk of hiring them.
- Satisfaction from learning more about quality measures, QI concepts and techniques, critical medical home components, and how to identify PCMH capacity and performance gaps.

Practice staff also reported a variety of challenges or weaknesses with aspects of the QI collaboratives. These included:

- Difficulty learning from other practices with dissimilar QI and PCMH capacity and patient populations, or different topic area and measurement interests.
- A sometimes overwhelming amount of materials and ideas covered during in-person QI collaborative sessions.
- Difficulty keeping up with Webinars, calls, and Web sites/blogs given competing practice demands.
- The challenges of motivating and sharing information with other practice staff not attending collaborative sessions.

States and practices also seemed to agree that QI collaboratives and related activities may be necessary but are perhaps not sufficient to facilitate QI and PCMH capacity improvement, suggesting the need for additional QI strategies. However, states had mixed experience with and reactions to these other strategies.

Practice facilitation was valued by practices as helping them stay focused and make progress between QI sessions. Practices also appreciated the customized feedback and assistance. However, the value of practice facilitation

may vary depending on how frequently facilitators visit, the knowledge and skills of the facilitator, and the information the facilitator makes available to the practice. Practice facilitation can also be relatively expensive for states to provide. As noted, experiments in Massachusetts to train existing practice staff to fill this role have potential for scale-up and spread.

In several states, workforce augmentation was initially considered a major plus for both practice recruitment and ongoing engagement. However, this strategy came to be viewed somewhat less favorably because some physicians believed the care coordinators hired did not have the right background or sufficient training, and some practice nurses thought that their roles overlapped with care coordinators.

On a related note, practice-level quality data collection and measurement was valued, but some practices thought that the burdens outweighed the benefits. Although the Initial Core Set of measures can mostly be calculated from existing state data (eg, claims, immunization), the measures are calculated too infrequently to be useful for practice-level QI efforts (eg, annually vs monthly or quarterly). Therefore, states wanted to experiment with the use of EHRs and state health information exchanges for practice-level quality measurement, but they encountered a number of challenges.²⁰

Regarding practice-specific family advisory councils or partners, practices said they are important but found it difficult to identify parents who can serve in a QI role, find tangible and practical ways to involve them, and keep them engaged over time.

DISCUSSION

States are using a full array of QI approaches to help practices improve the quality of care provided to children and to adopt the PCMH model. Although QI collaboratives began as targeted efforts to increase adherence to well-defined evidence-based guidelines,²⁵ the QI collaboratives and ancillary strategies used in the CHIPRA quality demonstration have the more challenging task of not only of trying to improve quality in a number of clinical areas but also driving complex practice transformation. Furthermore, the CHIPRA quality demonstration targets a diverse set of practices that typically serve relatively large proportions of children insured through Medicaid and CHIP, which generally have fewer resources than practices that serve commercially insured children. Given the varying goals and contexts of the practices participating in the demonstration collaboratives, it is not surprising that the demonstration states differ in their QI collaborative approaches.

The ambitiousness of the QI collaborative aims, coupled with the plethora of change-inducing initiatives that are being leveled at practices, present a challenging environment. Practices report that even with stipends and workforce augmentation, full participation in QI collaboratives can be very taxing. Customized facilitation represents an attractive form of QI assistance, but the

cost of facilitation of sufficient quality and intensity may not be financially sustainable for states, particularly if they choose to involve more practices over time.

To align QI assistance targeting child-serving practices and increase sustainability, state Medicaid and CHIP agencies may be able to partner with other payers and change agents to continue QI strategies. For example, multipayer collaboratives are a new engine driving health care delivery improvement.^{26–28} By teaming up with others with similar agendas, public agencies may be able to leverage the knowledge they have gained through their demonstration projects. Medicaid and CHIP agencies can also explore taking advantage of other change agents working with providers. For example, practice facilitators from HITECH Regional Extension Centers that are helping practices implement EHRs, exchange health information, and achieve stage 1 meaningful use²⁹ are being trained in PCMH promotion, and some states are aligning Medicaid meaningful use clinical quality measures with PCMH and QI efforts (4 Initial Core Set measures overlap with stage 1 meaningful use measures). Other sources of facilitation could come from practice-based research networks, health plans, and CMS-sponsored External Quality Review Organizations.³⁰ Additionally, the Primary Care Extension Program, which was authorized by the Affordable Care Act but has not yet been funded, could provide a mechanism for sustaining practice-level QI assistance.

The CHIPRA quality demonstration projects seem poised to achieve 2 outcomes: 1) to provide further insight and learning into how best to use QI collaboratives and complementary strategies to support child-serving practices in QI and PCMH development; and 2) to share this knowledge with nondemonstration states and with practices interested in PCMH for populations of all ages. If some of the CHIPRA demonstration projects positively affect patient care and quality outcomes, the next challenge will be to identify the blend of QI collaborative features and strategies that resulted in success, in what contexts, and how they can be sustained and spread. Evaluators will utilize additional qualitative (eg, second round of site visits and family focus groups) and quantitative (eg, provider survey and claims data) data to assess whether positive outcomes have been achieved, and if so, what QI collaborative features and strategies are associated with these positive outcomes.

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