PERFORMANCE MEASURES

Meeting Quality Measures for Adolescent Preventive Care: Assessing the Perspectives of Key Stakeholders

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Background: Health plans are increasingly implementing quality improvement strategies aimed at meeting adolescent clinical quality measures, yet clinics often struggle to meet these measures. This qualitative study was conducted to explore how efforts to meet the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) performance measure for adolescent well-care visits were perceived by a multidisciplinary group of stakeholders.

Methods: The research team conducted 26 in-depth, semistructured interviews with participants from three stakeholder groups: clinic staff with direct patient contact, health care institutional leaders, and representatives of a payer organization. Interviews were about 45 minutes in duration, audio-recorded, and professionally transcribed. Framework analysis was used to identify and organize emergent themes, and Atlas.ti was used to facilitate data management and analysis.

Results: Stakeholder groups diverged in their opinions regarding strategies for achieving adolescent quality measures. Stakeholders with no direct patient interaction touted transactional quality improvement strategies that directly incentivized patients and families. In contrast, clinic staff with direct patient contact believed that incentive-based efforts undermined patient-provider relationships and the clinics’ focus on wellness.

Conclusion: A considerable disconnect exists between stakeholders with and without patient contact with regard to approaches to the delivery of well care and quality improvement strategies for meeting the adolescent well-care visit performance measure. Efforts to reconcile discordant perspectives and promote a mutual understanding between payers, institutional leaders, and clinic staff could inform the development of creative initiatives that are sustainable and effective at achieving adolescent and family engagement, as well as clinical performance benchmarks.

Regular well care is important for addressing the unique physical, mental, and developmental needs of adolescents. Screenings, counseling, and anticipatory guidance provided during adolescent well-care visits are aimed at reducing risky or unhealthy behaviors that contribute to leading causes of morbidity and mortality for this population. Several national health care organizations in the United States have affirmed the importance of regular well care by providing evidence-based practice guidelines, including the American Academy of Pediatrics’ Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, and The American Medical Association’s Guidelines for Adolescent Preventive Health Services (GAPS). Despite the importance of well care, utilization by adolescents often falls short of meeting national guidelines. One possible explanation is that a large proportion of adolescents do not see a primary care provider on an annual basis, even though most adolescents report having a usual source of care. In addition, even adolescents who use health care at high rates often fail to receive recommended well-care services. The National Committee for Quality Assurance (NCQA) developed the Healthcare Effectiveness Data and Information Set (HEDIS) as a standardized way to collect and measure information on the quality of care and service provided by health plans. HEDIS includes among its 81 measures an “annual adolescent well visit” with a primary care provider or an obstetric/gynecological practitioner, which specifically assesses “whether enrollees turning 12–21 years of age during the measurement year had at least one well visit in the measurement year.” HEDIS is used by more than 90% percent of health plans across the United States and is often linked to financial rewards or penalties for providers based on performance. Its increasing application has resulted in health plans developing targeted initiatives and quality improvement (QI) strategies to improve clinics’ performance with respect to HEDIS measures. Despite these efforts, utilization of preventive care by adolescents remains low, and clinics often struggle to meet minimum benchmarks.

Although some research has sought adolescent and family perspectives on QI strategies aimed at increasing utilization of health care, few have included the perspectives of health plans, providers, and clinic staff who are involved with the inception and implementation of QI initiatives, and also engaged in the broader effort of delivering comprehensive primary care. Little is known about the potential influence of QI efforts on pediatric clinical practice,

1553-7250/$-see front matter Published by Elsevier Inc. on behalf of The Joint Commission. https://doi.org/10.1016/j.jcjq.2017.07.008
patient-provider relationships and interactions, or the organizational factors that may affect the success or failure of such efforts. Furthermore, although practice-level QI strategies have been studied in clinical practice settings that serve adult patient populations, few studies have done so in pediatric practices. The objective of this qualitative study was to examine stakeholder perspectives of QI efforts aimed at improving adolescent well-care visit rates and to explore how these perspectives may differ between different stakeholder groups. Specifically, we explored perspectives related to approaches to well-care delivery and perceptions of how QI strategies to meet these performance measures affect clinical processes and relationships between providers and families.

METHODS

Study Setting
Study participants were recruited from two academically affiliated primary care clinics located in an urban area. The first was a pediatric primary care clinic serving a low-income urban population. The clinic served as a medical home for nearly 8,000 patients aged 0 to 25 years (including 4,300 adolescents aged 11 to 21 years). Approximately 90% of the patient families were non-Hispanic black, and more than 90% were covered under public insurance (that is, Medicaid or the Children’s Health Insurance Program [CHIP]). The second study setting was a private pediatric clinic serving an urban/suburban population that was both racially/ethnically and socioeconomically diverse. This clinic was part of a larger network of 30 clinics located throughout the state that served a total of about 23,000 adolescents per year. Both clinics were led by multidisciplinary teams of providers, administrative staff, and institutional leaders from the academic institution. Clinic leaders from both sites calculated the current "no-show rate" for scheduled adolescent well-care visits to be more than 50%, noting that this figure was higher for patients covered under Medicaid.

Study Population and Recruitment
Stakeholders were identified to participate in the study to gain perspective on recruitment clinic staff, institutional leaders, and payers. Clinic staff were those individuals who directly interfaced with patients as part of their primary job responsibilities, and included physicians, nurses, social workers, and administrative staff. Institutional leaders were employed by the academic institution and involved with performance measurement across multiple health care settings. “Payers” were individuals employed by the payer organization whose products include managed care plans for commercial, Medicaid, and military family populations. Recruitment efforts for the payer organization focused on senior leadership primarily responsible for QI initiatives, performance measurement, and provider relations.

The participants were interviewed from June 2014 through September 2014 until saturation of themes was achieved during an iterative analysis process, and written informed consent was obtained prior to conducting each interview. On conclusion of each interview, study participants were asked to recommend colleagues who might be interested in participating. All individuals who were recommended went on to be successfully interviewed for this study. The study protocol was approved by the Johns Hopkins Medicine Institutional Review Board.

Data Collection
The qualitative research methods in this study were grounded in a phenomenological approach, which emphasized individuals’ experiences and interpretations of a particular situation (or phenomenon), and enabled us to capture perspectives from a broad array of stakeholders. The research team developed a structured interview guide containing primary discussion and follow-up questions, as well as optional probes to guide the discussions with respondents as they described their role and perceptions related to well-care delivery for adolescents, knowledge of performance measures and utilization benchmarks, role in developing or implementing QI initiatives, thoughts on current or past QI initiatives undertaken at the clinics specific to adolescent patients and families, and the personal and professional impact of their involvement with performance measurement or QI (Sidebar 1). The interviews averaged approximately 45 minutes in duration and were conducted until the research team determined that saturation of themes was achieved within and across stakeholder groups. All interviews were audio-recorded and professionally transcribed, and transcripts were de-identified prior to analysis.

Data Analysis
Two members of the research team [S.R.P., D.M.] with a background in health services research and prior experience employing qualitative research methods collaborated to create and refine a coding matrix, which was used to capture emergent themes using framework analysis. Framework analysis is an approach to conducting data management and analysis that attempts to draw out descriptive information clustered around themes through familiarization, identification of a thematic framework, coding, charting, mapping, and interpretation. It is well suited for use in applied social science research and offers a systematic method for identifying and summarizing data collected through semistructured interviews into an organized coding matrix.

To minimize potential bias during data analysis and to ensure the reliability and validity of results, a coding scheme was agreed on by both coders for this study. At the onset of data collection, five interview transcripts across stakeholder groups were coded by both coders, so that they were double-coded, and each researcher independently developed a thematic template before convening to discuss commonalities and resolve discrepancies. These same five interviews were subsequently double-coded during two...
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