

Primary Care Physicians' Experiences With and Attitudes Toward Pediatric Quality Reporting

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ABSTRACT

OBJECTIVE: To assess primary care providers' experiences with receiving quality reports related to pediatric care



attitudes toward quality reporting are key influences on the effectiveness of these efforts,¹⁶ but few studies have assessed the experiences with and attitudes toward quality reporting for primary care providers for children.^{6,17}

DEPENDENT VARIABLES

We focused on several variables identified in the literature and by demonstration states as key intermediate steps between quality measurement, quality reporting, and QI

Table 1. Individual and Practice Characteristics of Primary Care Pediatricians and Family Physicians Who Provide Care to Children Covered by Medicaid and CHIP in North Carolina, Ohio, and Pennsylvania, 2014

Characteristic	Full Sample (n ¼ 727)	Pennsylvania (Exposed; n ¼ 55)*	Pennsylvania (Unexposed; n ¼ 187)	North Carolina (n ¼ 242)†	Ohio (n ¼ 243)‡
Age in years, weighted mean (SD)	50.6 (10.5)	49.7 (8.9)	52.3 (11.6)	48.7 (9.6)	51.3 (10.6)
Years since medical school graduation, weighted mean (SD)	23.5 (10.9)	23.6 (10.1)	25.6 (11.8)	21.2 (9.9)	24.0 (10.8)
Specialty, weighted % (95% CI)					
Pediatrics§	41.9 (38.8–45.0)	72.0 (62.5–81.4)	33.5 (28.1–39.0)	45.2 (39.9–50.6)	42.8 (37.5–48.0)
Family medicinek	58.1 (55.0–61.2)	28.0 (18.6–37.5)	66.5 (61.0–71.9)	54.8 (49.4–60.1)	57.2 (52.0–62.5)
Employment, weighted % (95% CI)					
Owner	36.7 (33.6–39.9)	8.9 (1.7–16.0)	36.6 (30.4–42.8)	39.6 (34.2–44.9)	39.1 (33.8–44.5)
Employee	62.9 (59.8–66.1)	91.1 (84.0–98.3)	63.4 (57.2–69.6)	60.0 (54.7–65.4)	60.2 (54.8–65.6)
Contractor	< 1	< 1	< 1	< 1	< 1
Practice characteristics					
Number of physicians in practice, median (IQR)	4 (2–6)	5 (3–8)	3 (2–5)	4 (2–6)	3 (2–6)
Any nurse practitioners, weighted % (95% CI)	47.8 (44.0–51.7)	64.6 (51.0–78.1)	46.4 (38.7–54.1)	50.8 (44.3–57.3)	44.4 (37.9–50.8)

Table 2. Primary Care Pediatricians' and Family Physicians' Experiences With and Attitudes About Pediatric Quality Reporting in North Carolina, Ohio, and Pennsylvania, 2014

Experience	Weighted % (95% CI)						
	Full Sample	Pennsylvania (Exposed)*	Pennsylvania (Unexposed)	North Carolina†	Ohio‡	Pediatricians	Family Physicians
Received pediatric quality reports from external sources							
Any source	79.8 (77.2–82.4)	91.8 (85.6–97.9)	86.7 (82.0–91.3)	72.3 (67.5–77.2)	77.0 (72.3–81.7)	92.9 (90.6–95.3)	70.3 (66.2–74.4)
Commercial plans	58.6 (55.4–61.8)	79.5 (70.2–88.8)	76.4 (70.7–82.0)	48.3 (42.9–53.8)	46.1 (40.6–51.5)	72.4 (68.3–76.5)	49.0 (44.3–53.6)

multivariable analyses, exposed and unexposed physicians in Pennsylvania had higher odds of receiving pediatric quality reports (adjusted odds ratio [AOR], 1.98; 95% confidence interval [CI], 0.66–5.90 and AOR, 2.20; 95% CI, 1.15–4.23, respectively) and receiving quality reports with key pediatric quality measures (AOR, 2.64; 95% CI, 0.97–7.17 and AOR, 3.05; 95% CI, 1.70–5.49, respectively) compared with physicians in Ohio, although the results were only significant for unexposed physicians. Physicians in North Carolina had significantly lower odds of reporting receiving quality reports with key pediatric quality measures compared with those in Ohio (AOR, 0.57; 95% CI, 0.37–0.88). There were no significant differences between these groups in reporting pediatric QI efforts in the previous 2 years or reporting using quality reports in pediatric QI. Compared with family physicians, pediatricians had significantly higher odds of receiving pediatric quality reports (AOR, 6.16; 95% CI, 3.62–10.49), receiving quality reports with key pediatric quality measures (AOR, 2.79; 95% CI, 1.76–4.41), engaging in child-focused QI (AOR, 4.37; 95% CI, 2.75–6.93), and using quality reports in child-focused QI (AOR, 1.55; 95% CI, 1.02–2.35). Physicians practicing in formally recognized medical homes had significantly higher odds of receiving pediatric quality reports (AOR, 1.91; 95% CI, 1.19–3.06) and using quality reports in child-focused QI (AOR, 2.02; 95% CI, 1.40–2.93).

PHYSICIAN ATTITUDES ABOUT QUALITY REPORTING

Overall, approximately 70% of the physicians believed that quality reports were moderately or very effective for improving care for children (Table 2). There were no significant differences in this attitude across state groups, specialty, or practice characteristics (Table 3). Most of the child-serving primary care physicians believed it would be useful to receive quality reports that included information about their own patients and all patients in the practice, comparisons with a variety of benchmarks internal and external to their practice, quality measures for children (of)tions, pracpa.410 0 gvedmeasus4407.8(95ild-1(car

thus, reflected primary care practices' priorities. Respondents also described financial incentives as key potential

Table 5. Experiences and Attitudes Toward Quality Measurement and Reporting: Thematic Analysis of Interviews With CHIPRA Quality Demonstration Grant Program State Leaders and Participating Primary Care Physicians in North Carolina and Pennsylvania

Theme	Subtheme	Illustrative Quote
Facilitators to engaging providers in quality measurement and reporting efforts	Alignment of measurement and reporting with existing practice services and priorities	“Being a pediatrician, I think if you look at 24 measures, it could be considered overwhelming. But when I look at it, it is part of what I was doing.”
	Introduction of a limited number of measures at a time	“If you really want to do something with QI, you’ve got to focus it down. Doing QI and moving measures doesn’t happen overnight, especially trying to introduce population management and going through those steps, it takes time. I think there are way too many measures ” “We’re down to 8. They were all great measures. The challenge of some of the 24 was that some were hard to get good data on. Some things require multiple databases, like ER measures where we need to integrate outpatient and inpatient EHRs and assume no one went to other another ER. I thought that the set of 8 so far are all reportable. But the 24 are all good goals.”
	Education of providers on coding and billing for services targeted by quality measures	“We worked with the folks at the state level to train all of our Qis to provide dental varnishing training to practices. It’s one of the easiest sells. It reimburses at \$52 per varnish and the provider doesn’t have to do it themselves The fact that it reimburses so well is a helpful

Contrary to our hypotheses, physicians’ experiences than those in Ohio. Our qualitative findings from North Carolina did not shed light on why there was not a higher level of exposure to quality reports there, but rates in North Carolina or Pennsylvania. Although Ohio might have been higher than anticipated because of a large regional pediatric Medicaid accountable care organization in Pennsylvania were more likely to receive pediatric quality reports compared with physicians in Ohio, this was also true for other physicians in Pennsylvania, which suggests other statewide influences. Surprisingly, despite a pediatric quality reporting program that was focused statewide in North Carolina, physicians there were not more likely to report exposure to pediatric quality reporting than those in Ohio. The results from this study should be viewed in the context of several limitations. First, the design of the demonstration and this study create a possibility of confounding for any comparisons between 2 or more groups

of physicians. We adjusted for observable characteristics in our multivariable modeling within the limits of this approach. Second, the survey was conducted in 3 states and exposed physicians in Pennsylvania were primarily from large, integrated health systems, potentially limiting generalizability to other states. However, the personal and practice demographic characteristics of physicians in this study are similar to those of other recent studies of pediatricians and family physicians.³²⁻³⁴ Third, the response rate raises the possibility of nonresponse bias, although a nonresponse bias analysis was reassuring within the limits of observable data from our sampling frame and survey responses. Fourth, we could not account for all public and private sector quality measurement and reporting activities that could be occurring in these states that might have influenced results. Fifth, respondents in our qualitative interviews were self-selected participants in the demonstration program and might not represent the views of a broader population of child-serving primary care physicians in their states.

CONCLUSION

In this 3-state study, we found that most primary care physicians who serve publicly insured children received pediatric quality reports and believed that reports can be an effective tool to improve care. However, relatively few physicians used quality reports to guide their practices' QI efforts despite a concerted state program to increase such use. For quality reporting to achieve its promise, additional interventions are likely to be required, such as financial incentives and training physicians and practice staff in the use of quality reports to guide improvement activities.

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