Table 1. Topics Taught in 12 States' Quality Improvement Collaboratives (as of 2015)

Conceptual Grouping of Collaborative Features Identified by Interviewees

Sidebar 2. Interview Guides Description

Separate interview guides were developed for different types of interviewees, to reflect the different topics that different interviewee types would be able to comment on, and the different ways questions would need to be phrased depending on an individual's role in a state's Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) quality demonstration.[1] Interviewee types were as follows:

1. Key staff (that is, the state Medicaid staff and/or contractor[s] leading the design and overseeing the implementation of CHIPRA quality demonstration activities)
2. Other implementation staff (for example, state staff and/or contractors implementing CHIPRA quality demonstration activities)
3. Medicaid managed care organization / private health insurance company executives who were aware of the state's CHIPRA quality demonstration activities
4. External stakeholders (for example, staff of other state agencies or nonprofit organizations who sat on a committee advising state Medicaid staff on the design and implementation of their CHIPRA quality demonstration activities)
5. Health care organization staff (staff of primary care practices participating in a state's demonstration activities, including physicians, nurses, and office managers).

CHIPRA quality demonstration states could pursue activities in up

Sidebar 3. Recommended Approaches for Quality Improvement Collaboratives

To Attract Participation . . .

- Offer maintenance of certification or continuing medical education credits in exchange for participation.
- Align collaborative content with external financial incentives (for example, pay-for-performance measures).
- Hire a collaborative organizer who is respected, neutral, and the same medical specialty as participants (for example, a pediatrician, if participants are mostly pediatricians).
- Have national experts give presentations at collaborative meetings.

To Maintain Engagement . . .

- Limit the focus of the collaborative to a narrow topic (for example, one clinical condition).
- Require practice teams to include a physician champion, a nurse, and administrative staff.
- Meet one-on-one with each practice before the collaborative starts to articulate participation and data collection expectations.
- Limit the duration of in-person meetings to 4–6 hours, and offer frequent 15-min. breaks and dedicated "team time"—so practices can develop plans to implement changes learned about during meetings.
- Minimize the use of conference calls and webinars, except in rural areas (where practices view these more favorably because they dislike traveling long distances for in-person meetings).
- If stipends are used, tie disbursal to participation requirements.
- Instead of websites that require passwords (which are hard to remember), use group e-mails.
- Have practice facilitators work one-on-one with practices on an ongoing basis to answer questions.
- Require practices to regularly complete PDSA exercises as homework.
- Distribute quality measure reports showing how participating practices compare to each other to stoke friendly competition.
- Frequently solicit attendee feedback (such as through satisfaction surveys), and make mid-course adjustments that reflect attendee needs and preferences.

To Facilitate

had parents give presentations at collaborative meetings, which they told us received practices' highest ratings in meeting evaluations. An interviewee from one practice in that state, in turn, told us about useful feedback they obtained through a focus group they conducted with Spanish-speaking parents: The parents identified information to prioritize for inclusion in a new Shared Care Plan template and noted that if care plans were produced in both Spanish and English, parents would be better able to explain their children's diagnoses to other English-speaking providers.

DISCUSSION

This study peers into the "black box" of collaboratives to identify interviewees' views on various collaborative features. Some of our findings are new, and fall into all three of our categories. Specifically, to attract participants, our interviewees recommended o□ering MOC or CME credits, aligning content with external financial incentives (for example, pay-for-performance measures), and contracting with respected collaborative organizers of the same medical specialty as most participants. They also believed that stipends could help attract participation but cautioned that they sometimes did not reach intended recipients. New findings related to maintaining

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