Variation in Outcomes of Quality Measurement by Data Source

WHAT’S KNOWN ON THIS SUBJECT: Administrative health insurance claims have limitations when measuring care quality.

WHAT THIS STUDY ADDS: Children’s care quality measures assessed using administrative claims alone may not accurately reflect care quality. Use of electronic health record data in combination with administrative claims data provides an opportunity for more complete measurement.

abstract

OBJECTIVE: To evaluate selected Children’s Health Insurance Program Reauthorization Act claims-based quality measures using claims data alone, electronic health record (EHR) data alone, and both data sources combined.

METHODS: Our population included pediatric patients from 46 clinics in the OCHIN network of community health centers, who were continuously enrolled in Oregon’s public health insurance program during 2010. Within this population, we calculated selected pediatric care quality measures according to the Children’s Health Insurance Program Reauthorization Act technical specifications within administrative claims. We then calculated these measures in the same cohort, by using EHR data, by using the technical specifications plus clinical data previously shown to enhance capture of a given measure. We used the κ statistic to determine agreement in measurement when using claims versus EHR data. Finally, we measured quality of care delivered to the study population, when using a combined dataset of linked, patient-level administrative claims and EHR data.

RESULTS: When using administrative claims data, 1.0% of children (aged 3–17) had a BMI percentile recorded, compared with 71.9% based on the EHR data (κ agreement [κ] = 0.01), and 72.0% in the combined dataset. Among children turning 2 in 2010, 20.2% received all recommended immunizations according to the administrative claims data, 17.2% according to the EHR data (κ = 0.82), and 21.4% according to the combined dataset.

CONCLUSIONS: Children’s care quality measures may not be accurate when assessed using only administrative claims. Adding EHR data to administrative claims data may yield more complete measurement.

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KEY WORDS: pediatrics, quality of care, electronic health records, Medicaid

ABBREVIATIONS
CHIP—Children’s Health Insurance Program
CHIPRA—Children’s Health Insurance Program Reauthorization Act
EHR—electronic health record
ICD-9—International Classification of Diseases, Ninth Revision
ICD-10-CM—International Classification of Diseases, Tenth Revision, Clinical Modification
OHP—Oregon Health Plan

Ms Angier helped conceptualize and design the study, and drafted the initial manuscript; Drs Gold, Gallia, and DeVoe conceptualized and designed the study, and critically reviewed the manuscript; Ms Cassiato helped design the study, and critically reviewed the manuscript; Ms Tillotson and Dr Marino carried out analyses, and reviewed and revised the manuscript; Dr Mangione-Smith critically reviewed the manuscript; and all authors approved the final manuscript as submitted.

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The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), intended to increase the number of children with health insurance, also mandated that a set of pediatric care quality measures be selected. An initial set of 24 CHIPRA core measures, chosen for their validity, importance to health outcomes, and ability to be evaluated by using states’ Medicaid administrative claims data, were identified by experts to meet this mandate.

States are encouraged to report on the CHIPRA measures to assess the quality of care provided to children in their Medicaid program and Children’s Health Insurance Program (CHIP). Methods for operationalizing each measure are given in the CHIPRA Technical Specifications and Resource Manual. In most cases, these methods contain parameters for defining the population of children to include in the rate denominator, and a set of diagnostic and procedure codes from administrative claims data to identify provided care (the numerator). A “hybrid” method using manual chart review on a sample of children is also given for defining some of the measures; however, such reviews are rarely feasible for states to conduct, as obtaining medical record data can be difficult, costly, and time-consuming.

The CHIPRA measures are an important step toward standardizing pediatric care quality assessments. However, limitations to using administrative claims data for such purposes have been shown in previous research assessing care quality. Although adding data from discreet electronic health record (EHR) data fields shows promise in improving the accuracy of claims-based quality measurement, assessments using EHR data alone may have limitations. For example, in a study of the quality of care provided to adults with diabetes, neither Medicaid administrative claims nor EHR data alone yielded a complete capture of provided services: 12% of cholesterol screenings received were documented in Medicaid claims but not the EHR, 49% were documented in the EHR but not in Medicaid claims, and only 39% were documented in both data sources.

After the CHIPRA measures were initially developed, Gold et al determined which of these claims-based measures could feasibly be calculated by using electronically abstracted EHR data, and what modifications to the claims-based technical specifications were needed, if any, to enable such EHR-based measurement. Building directly on that landmark study, the present analysis sought to evaluate the accuracy of selected CHIPRA claims-based measures, when based on administrative claims data alone, EHR data alone, or both data sources combined. We also built on this previous work by assessing the quality of care delivered to a single cohort of continuously insured children who were established patients within the OCHIN network of community health centers.

**METHODS**

**Data Sources**

**Oregon Health Plan Administrative Data**

Oregon’s Medicaid and CHIP insurance programs are both operated by the Oregon Health Plan (OHP). The OHP pays clinics for provided health care, and thus receives claims (ie, diagnosis and procedure codes) for all OHP-insured children in Oregon.

**EHR Data**

“OCHIN, Inc.” originally the Oregon Community Health Information Network, provides and maintains a comprehensive Epic EHR infrastructure for member clinics. All sites share a single, linked EHR and patients have 1 unique record; data are stored in a central repository that can be searched electronically. All of the EHR data used in this study were pulled by using automated extraction from 46 OCHIN clinics in Oregon that had the full EHR implemented before July 1, 2009 (6 months before the study year).

**Study Population**

We selected a study cohort of children and adolescents (aged ≤21 years) who were continuously insured by OHP and had at least 1 outpatient visit at a study clinic in 2010 (n = 22,925 children). We deterministically linked records for these children who appeared in both the OHP claims and the OCHIN EHR datasets by using the child’s unique OHP client identification number. For all of the measures calculated here, we used the CHIPRA technical specifications’ definition of continuously insured: briefly, a child or adolescent must have 12 months of coverage with no more than one 45-day gap. Depending on the measure, different time periods apply for when the child/adolescent had to have continuous insurance; for example, the BMI percentile measure requires continuous insurance during the measurement year, whereas the childhood immunization measure requires continuous insurance during the year before the child’s second birthday.

**Measures**

We selected a subset of the CHIPRA measures for analysis based on those previously identified as feasible for assessment using EHR data and those most applicable to the children in our study population, including BMI percentile, recommended immunizations for children and adolescents, well-child visits, and Chlamydia screening for sexually active women. We did not include 2 current and feasible measures due to sample size: developmental...
screening had a small numerator \((n \sim 221)\) and follow-up care for children prescribed attention-deficit/hyperactivity disorder medication had a small denominator \((n \sim 151)\). The prenatal measures were beyond the scope of this project.

In analyses within administrative claims data, we used the exact measure specifications from the Initial Core Set of Children’s Health Care Quality Measures: Technical Specifications and Resource Manual for Federal Fiscal Year 2011. Optional exclusions for the measures were not used. In the assessments using electronically pulled EHR data, we calculated the measures by using the technical specifications (ie, CPT codes, and so forth) plus relevant clinical data (ie, historical immunizations, primary reason for the visit, and so forth) as outlined by Gold et al.12 See Table 1.

Analysis

First, we described the sociodemographic characteristics of the study population. Second, we assessed rates of receipt for each of the selected quality measures among the measure-specific subgroup of children in the study population, by using the administrative claims data, and again by using the EHR data (which included the additional fields unique to the EHR dataset described previously). Third, we tested for agreement in quality measurement using the administrative claims dataset versus the EHR dataset, by using the \(\kappa\) statistic. Fourth, we assessed care quality by using a linked dataset that combined the administrative claims and EHR data. Finally, among all services documented in the combined dataset, we determined the percentage found in claims alone, the EHR alone, or in both data sources. All analyses were conducted by using SAS software, version 9.3 (SAS Institute, Inc, Cary, NC). This study was approved by the institutional review board at Oregon Health & Science University.

RESULTS

Demographics

The mean age of the children in our study population was 8.5 years. More than half were white (52.4%) and nearly half were Hispanic (47.3%). The main languages spoken were English (45.5%) and Spanish (41.0%) (Table 2).

Measures Assessed by Using Claims Data Alone, EHR Data Alone, or a Combined Claims/EHR Dataset

BMI

In the administrative claims data, 1.0% of children (aged 3–17) in our study population had a BMI percentile recorded in...
the measurement year, compared with 71.9% in the EHR data (κ agreement [κ] = 0.01), and 72.0% in the combined claims/EHR dataset.

**Childhood and Adolescent Immunization Status**

Among children who turned 2 in 2010, 20.2% had received all their recommended immunizations, when measured by administrative claims data; 17.2% met the measure according to the EHR data (κ = 0.82). In the combined dataset, 21.4% had received all recommended immunizations. Among adolescents who turned 13 in 2010, 51.8% had received both a tetanus, diphtheria, acellular pertussis/tetanus, diphtheria and meningococcal immunization according to the administrative claims data, and 48.4% when assessed in the EHR data (κ = 0.82). In the combined dataset, 54.6% of adolescents were up-to-date.

**Well-Child Visits**

Among children who turned 15 months of age in 2010, 59.5% had received at least 6 well-child visits when measured by OHP administrative claims data. When measured in the EHR data, 60.5% were up-to-date on this measure (κ = 0.49). In the combined dataset, 72.2% of children were up-to-date. The same pattern held true for well-child visits for 3– to 6-year-olds and for adolescents: similar results were found in each data source when assessed separately, and the rate was higher when the data sources were combined.

**Chlamydia screening**

In the assessments using OHP administrative claims data, 41.1% of sexually active adolescent girls and young women aged 16 to 20 had a *Chlamydia* test; 76.0% of eligible adolescent girls and young women had a *Chlamydia* test according to the OCHIN EHR data (κ = 0.26). In the combined dataset, 78.8% of the eligible population had been screened (Table 3).

**DISCUSSION**

Increasingly, care quality assessed by using standardized methods, such as the CHIPRA core measures, will be used to calculate incentives or reimbursements. For example, in Oregon, coordinated care organizations will receive incentive payments based on the quality of care provided to Medicaid patients enrolled in their programs. Thus, it is increasingly important to understand the limitations inherent to measuring care quality by using different data sources, to ensure that these data provide an accurate reflection of the care provided.

This study found significant differences between claims and EHR data sources depending on the measure assessed: BMI was recorded in the EHR far more often than in claims, and immunizations were often recorded in claims data but not found in the EHR data. There are logical explanations for the lack of agreement between these 2 data sources. For example, the lack of information in claims about BMI assessment highlights a limitation of claims data: these data represent billed services only. Conversely, immunizations may be received at multiple care sites and billed to patients’ insurance plans, but not reported back to or reflected in their primary care medical home’s EHR.

Our findings suggest that most current methods for assessing care quality are limited because they are usually based on information obtained from 1 data source. If quality measurements use only administrative claims data, which document billed services and associated diagnoses, they are not capturing all of the care received or services provided. Similarly, quality measurements that use EHR data alone may not obtain a complete picture of all care patients receive, as EHR data often only include data from 1 clinic system, and patients may seek care at different locations. In this study population, combining administrative claims and EHR data yielded the most complete capture of data on the quality of care provided to children. These findings illustrate that different
information can be found in claims and EHR data; thus, accurate assessment of care quality may require combining these data sources. The "hybrid" method recommended for assessing CHIPRA quality measures, which includes medical record review, is likely more comprehensive than analyses that use administrative claims data alone. However, this method, as currently described, is difficult to execute because of time and financial constraints.9 We demonstrate an alternative data-collection method for those systems able to electronically abstract clinically relevant EHR data; this method may improve the ability to use medical record data for quality assessment.

**Impact on Policy**

The Medicaid Statistical Information System data, a national eligibility and claims database maintained by the Centers for Medicare and Medicaid Services, has been identified as a potential way to further standardize the CHIPRA core measures as states expand coverage by enacting provisions authorized under the Affordable Care Act.25,26 Using Medicaid Statistical Information System data will allow for state-to-state comparison, as measures will be calculated the same way from a national dataset. However, our results suggest that these data alone may yield an inaccurate measure of pediatric care quality. Policy makers should consider combining claims and EHR data to more accurately assess the quality of care provided to children insured by Medicaid and CHIP. As reimbursements are increasingly based on the quality of delivered care, it will be essential to access and use the most complete data available.27 As more and more health care providers have EHRs,28 health record data will be increasingly available.

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**TABLE 3  CHIPRA Measure Assessments: Quality Measurements Using OHP Claims, EHR, and Claims and/or EHR Data (2010)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total n</th>
<th>OHP Claims</th>
<th>EHR</th>
<th>Dataset Combining Information From OHP Claims and EHR</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI percentile documentation (3–17 y of age as of 12/31/2010)</td>
<td>11 791</td>
<td>68 (1)</td>
<td>8476 (71.9)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Immunizations: children5 (turned 2 y of age during 2010)</td>
<td>All recommended immunizations</td>
<td>1403</td>
<td>284 (20.2)</td>
<td>241 (17.2)</td>
</tr>
<tr>
<td></td>
<td>DTaP</td>
<td>1403</td>
<td>1166 (83.1)</td>
<td>1152 (82.1)</td>
</tr>
<tr>
<td></td>
<td>IPV</td>
<td>1403</td>
<td>1285 (91.6)</td>
<td>1257 (89.6)</td>
</tr>
<tr>
<td></td>
<td>MMR</td>
<td>1403</td>
<td>1295 (92.3)</td>
<td>1301 (92.7)</td>
</tr>
<tr>
<td></td>
<td>Hib</td>
<td>1403</td>
<td>1224 (87.2)</td>
<td>1226 (87.4)</td>
</tr>
<tr>
<td></td>
<td>Hep B</td>
<td>1403</td>
<td>1296 (92.4)</td>
<td>1248 (88.9)</td>
</tr>
<tr>
<td></td>
<td>VZV</td>
<td>1403</td>
<td>1271 (90.6)</td>
<td>1283 (91.5)</td>
</tr>
<tr>
<td></td>
<td>PCV</td>
<td>1403</td>
<td>1148 (81.8)</td>
<td>1138 (81.1)</td>
</tr>
<tr>
<td></td>
<td>Hep A</td>
<td>1403</td>
<td>603 (43.0)</td>
<td>591 (42.1)</td>
</tr>
<tr>
<td></td>
<td>RV</td>
<td>1403</td>
<td>961 (61.4)</td>
<td>689 (48.1)</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>1403</td>
<td>769 (54.8)</td>
<td>742 (52.9)</td>
</tr>
<tr>
<td></td>
<td>Combo 6&lt;sup&gt;e&lt;/sup&gt;</td>
<td>1403</td>
<td>1043 (74.3)</td>
<td>1035 (73.8)</td>
</tr>
<tr>
<td>Immunizations: adolescents6 (turned 13 y of age during 2010)</td>
<td>Tdap/Td</td>
<td>643</td>
<td>495 (77.0)</td>
<td>460 (71.5)</td>
</tr>
<tr>
<td></td>
<td>Meningococcal</td>
<td>643</td>
<td>358 (55.7)</td>
<td>343 (53.3)</td>
</tr>
<tr>
<td></td>
<td>Tdap/Td and Meningococcal</td>
<td>643</td>
<td>333 (51.8)</td>
<td>311 (48.4)</td>
</tr>
<tr>
<td>Well-child visits</td>
<td>Infants (turned 15 mo during 2010)</td>
<td>1453</td>
<td>852 (58.5)</td>
<td>867 (60.5)</td>
</tr>
<tr>
<td>6+ Visits</td>
<td>Children (3–16 y of age as of 12/31/2010)</td>
<td>4584</td>
<td>3160 (68.8)</td>
<td>3133 (68.2)</td>
</tr>
<tr>
<td>Well-care visits</td>
<td>Adolescents (12–21 y of age as of 12/31/2010)</td>
<td>5309</td>
<td>2064 (38.9)</td>
<td>2039 (38.4)</td>
</tr>
<tr>
<td>Chlamydia screening (16–20 y of age during 2010)</td>
<td>2550</td>
<td>1049 (41.1)</td>
<td>1937 (76.0)</td>
<td>0.26</td>
</tr>
</tbody>
</table>

All measures calculated from the same cohort of children; those continually insured by the OHP (administers both Oregon’s Medicaid Program and CHIP) with ≥1 outpatient visit in 2010 at 1 of the 46 Oregon clinics that had fully implemented OCHIN’s EHR before July 1, 2009.

Note Combo 3 and 6 were assessed because national recommendations were changing regarding Hep A and influenza, and RV was taken off the market for a period of time; these were thought to be possible explanations for why these rates might be lower.

<sup>a</sup> The OHP administers both Oregon’s Medicaid Program and CHIP.

<sup>b</sup> A statistic comparing agreement between quality measurement when using administrative data only versus EHR data only.

<sup>c</sup> Required immunizations for children: 4 diphtheria; tetanus, and acellular pertussis (DTaP); 5 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B), 1 chicken pox (VZV); 4 pneumococcal conjugate (PCV); 2 hepatitis A (Hep A); 2 or 3 rotavirus (RV); and 2 influenza vaccines by their second birthday.

<sup>d</sup> Combo 3: All required immunizations except Hep A, influenza, and RV.

<sup>e</sup> Combo 6: All required immunizations except Hep A and RV.

<sup>f</sup> Immunizations for adolescents: tetanus, diphtheria, acellular pertussis (Tdap), tetanus, diphtheria (Td) booster vaccine.
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