NATIONAL QUALITY FORUM

CONFERENCE CALL FOR THE CHILD HEALTH QUALITY MEASURES PROJECT TECHNICAL ADVISORY PANEL

October 18, 2010

Technical Advisory Panel Members Present: Allan Lieberthal, MD, FAAP (chair); Cheryl DeConde Johnson, EdD; Michael Earley, OD, FAAO; Michael Repka, MD; Rahul Shah, MD, FACS, FAAP.

NQF Staff Present: Reva Winkler, MD, MPH; Suzanne Theberge, MPH; Heidi Bossley, MSN, MBA; Hawa Camera, MPH; Emma Nochomovitz, MPH

Additional Participants: Sepheen C. Byron, MHS, National Committee for Quality Assurance (NCQA); John Eichwald, MA, FAAA, Centers for Disease Control and Prevention (CDC); Marcus Gaffney, MPH, CDC; David Granet, MD, FACS, FAAP, FAAO, University of California San Diego; Craig Mason, PhD, CDC

Introduction

Ms. Theberge, Child Health Quality Measures (CHQM) project manager, welcomed the members of the Technical Advisory Panel (TAP) to the call and thanked them for their participation. Ann Hammersmith, NQF general counsel, provided an introduction of disclosure of interest and invited TAP members to introduce themselves and describe any affiliations that need to be shared with the group to ensure transparency. The group did not have any conflicts of interest to disclose.

Dr. Winkler, CHQM senior director, provided the TAP members with a brief overview of NQF, the child health project, the role of the TAP and Steering Committee, and NQF's measure evaluation criteria. She emphasized the need for the TAP discussion to inform sub-criteria ratings for each measure and ultimately inform the Steering Committee's discussion at their meeting in early November. NQF staff requested that the TAP members document their sub-criteria ratings electronically following the call.

Measure Evaluation Discussion

Vision Measures

1398: Vision Screening (NCQA)

The TAP's main concerns about this measure included the following issues:

- brief description, numerator, and denominator of the measure are inadequately defined;

- measure fails to address sensitivity of different types of vision screenings (some of which are quite low) and their ability to affect quality outcomes;
- target age range does not correspond to evidence in favor of earlier screening and intervention;
- measure does not clearly encourage follow-up care; and
- target age for screening by age six not supported by evidence; many experts suggest the larger benefit is in screening younger children.

Ms. Byron, representing NCQA, explained that this measure belongs to a composite set of measures addressing overall child well care. The composite is aligned with a framework for childhood development and based on well child care visits at key ages (age ranges included by 6 months, 2 years, 6 years, 13 years, and 18 years of age). Ms. Byron described vision as one domain of the larger composite that the NCQA Expert Advisory Panel identified as important for children by age six. She explained that the measure is intended to include a two-year look back period, in response to the comments about the measure's target age for screening. Ms. Byron acknowledged the TAP's concern about the sensitivity of visual acuity testing and explained that they chose screening tests that are easily identifiable within the medical chart to make the measure more feasible and achievable. She explained that the numerator includes additional criteria beyond a visual acuity test:

- visual screening results for visual acuity are documented for each eye separately;
- evidence of confirmatory testing, referral, or treatment in the case of abnormal or indeterminate results; and
- documentation of optometrist or ophthalmologist visit.

The TAP found these clarifications from the measure steward helpful, but remained concerned about visual acuity as a screening methodology for each of the age groups, the measure's failure to ensure follow-up assessment or intervention, and the feasibility of a measure requiring manual audit of medical records. According to one member of the TAP, the measure submission form inaccurately cites support from the American Optometric Association (AOA) in favor of vision screening at certain ages. The AOA supports vision examinations, but does not support screenings without assured follow-up. Despite these concerns, several members of the TAP thought this measure could serve as an initial step toward addressing child vision care and implementation with electronic health records (EHRs) in the future.

1412: Pre-school vision screening in the medical home (AAP)
The discussion of this measure focused on the following concerns:

- measure focus on the medical home may be inappropriate because it excludes children who have appropriate screening outside of the medical home (e.g., optometrist, ophthalmologist, school program);

- lack of clarity about the exclusion of patients/parents who refuse the screen and the potential for this exclusion to leave out uncooperative children—a group that is high risk for vision problems;
- numerator focuses on low sensitivity screening methodologies (e.g., visual acuity and photoscreening);
- feasibility of data collection given that exclusions can only be generated via chart review; and
- feasibility of using a higher sensitivity vision screen given that current procedural terminology (CPT) codes cannot differentiate between vision tests of varying sensitivity (e.g., five foot Lea system) and the rapid evolution of diagnostic techniques.

Comparing measure 1398 and 1412
The TAP thought that measure *1412: Pre-school vision screening in the medical home* is simpler, easier to understand, and more appropriately focused on earlier intervention than the similar vision screening measure submitted by NCQA. According to the TAP, this measure addresses an important area of concern for child health.

As the measure steward was unavailable to respond to the TAP's concerns, NQF staff will follow up with the American Academy of Pediatrics (AAP). .

Hearing Measures
1402: Newborn Hearing Screening (NCQA)
The TAP noted that this measure addresses an important area of care and is based on available and appropriate data. However, the group was concerned about the lack of explanation regarding the type of screening being performed. The NCQA representative clarified that the focus of this measure is to address whether the newborn screening result appears in the outpatient physician chart. After this explanation, the TAP recognized the intention of the measure to focus on care coordination among pediatricians and recommended the following title change, *Children who have documentation in medical record that a newborn screening was done by six months of age.*

The TAP also discussed the feasibility and burden involved in this measure, given that it requires manual chart audit. The measure steward reassured the group that NCQA intends to eventually use this measure with electronic health records (EHRs).

CDC hearing measures
The TAP identified the following strengths related to this group of measures:
- good evidence and data to support the measure focus;

- continued follow-up care is addressed and individual measures complement each other well; and
- potential to use EHR data improves feasibility.

The TAP raised several overarching concerns:

- limitation of defining interventions solely as hearing aids;
- feasibility of collecting data for eight measures may be problematic, especially if surveillance data is used;
- feasibility of collecting numerator and denominator;
- homebirths not captured in measures; and
- all measures are currently untested using EHRs.

In addition to these overarching comments, the TAP discussed:

- measure *1356: Hearing screening refer rate at hospital discharge (EHDI-1b)*, which the Steward explained is intended to focus on the effectiveness of the screening equipment; and
- importance and feasibility of the measures focused on identifying risk factors (*1338* and *1359*).

Representatives from Centers for Disease Control and Prevention (CDC) acknowledged the TAP's concerns and emphasized the four components of these measures when reviewed as a sequence:

1. screening;
2. identification of risk factors;
3. audiological evaluation; and
4. intervention.

The CDC representatives explained that the numerator and denominator data for the risk factor measures are intended to be collected through Systematized Nomenclature of Medicine—Clinical Terms (SNOMED) and Logical Observation Identifiers Names and Codes (LOINC®) codes in EHRs. The measure development group intentionally avoided the use of CPT administrative codes, but has made an effort to harmonize the new EHR codes with both CPT and International Classification of Diseases, 9th Revision (ICD-9) codes.

It was noted that measures *1354, 1360,* and *1361* have been used as public health surveillance measures for many years, while the remaining five measures have not been tested.

The TAP noted that the CDC measures are individual measures and they are useful as a sequence.

There were no public comments.

Next Steps

Ms. Theberge will be sending the TAP a summary of the call and an electronic survey to rate the sub-criteria of these measures. The survey will need to be completed by the close of business on Wednesday, October 20, 2010. The results of the survey, the TAP's comments, and the call summary will be shared with the main Steering Committee. She also explained that the dental measures originally included for review in this TAP will be reviewed by the Steering Committee in November, due to time limitations on the TAP call.