NATIONAL QUALITY FORUM

Memo

TO: Health and Well-Being Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss NQF Member and Public Comments

DA: July 28, 2014

Background

Population health includes a focus on health and well-being, along with disease and illness, prevention and health promotion, and disparities in outcomes and improvement activities within a group and/or between groups. In 2011, as part of an HHS-funded project on population health measures, NQF commissioned a white paper that presented an environmental scan of existing measures and community health improvement priorities; proposed analytical frameworks for assessing and measuring population health; identified areas of alignment between the clinical care system and public health system; and outlined methodological issues related to population health measure development. This foundational paper and the National Quality Strategy (NQS) three-tiered approach to working with communities to promote healthy living and well-being, helped to inform this most recent project on health and well-being. This project evaluates measures that assess health-related behaviors (e.g., smoking, diet, exercise, substance use); community-level indicators of health and disease (e.g. disease incidence and prevalence); primary prevention and screening (e.g., influenza immunization); practices to promote healthy living; community interventions (e.g., mass screening); and modifiable social, economic, environmental determinants of health with demonstrable relationship to health and well-being. The scope also includes measures that address community-level indicators, such as preventable admissions related to diabetes and social and environmental determinants of child health, as well as individual-level measures of health and well-being.

NQF convened a Standing Committee comprised of 24 individuals to evaluate the measures in this project. The Standing Committee consists of consumers, purchasers, providers, healthcare professionals, health plans, suppliers, community and public health professionals, and healthcare quality experts. The Committee reviewed 15 measures, 12 of which were recommended for endorsement. The Committee did not reach consensus on three measures.

Purpose of the Call

The Health and Well-Being Standing Committee will meet via conference call on August 6, 2014, from 1:00-3:00pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation Member and Public Comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Determine whether reconsideration of any measures or other courses of action are warranted.

Due to time constraints, during this call we will review comments by exception—i.e., instances where the Committee disagrees with the proposed response.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 1-888-799-0466 (*NO CONFERENCE CODE REQUIRED)*

Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?624473

Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?624473

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits Member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both Members and the public after measures have been evaluated by the full Committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

For this evaluation cycle, the pre-evaluation comment period was open from March 13, 2014, until April 2, 2014 for the 15 measures under review. Nineteen pre-evaluation comments were received. All comments were favorable and did not raise significant issues about the measures.

Six comments specifically solicited clarification on how to interpret what was deemed "good" and "bad" rates used in some of the evaluated Prevention Quality Indicators (PQI) measures stewarded by the Agency for Healthcare Research Quality (AHRQ): *0272: Diabetes Short-Term Complications Admission Rate (PQI 01); 0280: Dehydration Admission Rate (PQI 10); 0281: Urinary Tract Infection Admission Rate (PQI 12);* and *0638:Uncontrolled Diabetes Admission Rate (PQI 14)* and the PDI measures*: 0727: Gastroenteritis Admission Rate (PDI 16)* and *0728: Asthma Admission Rate (PDI 14).* NQF also received three comments questioning how the denominators for diabetes PQI measures 0272, 0274 and 0638 are defined. The commenter indicated that the entire population in the county where the patient resides is not at risk for the outcome, since the majority does not have diabetes, and that it would be best to use a diabetes-specific population in the denominators for these indicators. The commenter also suggested the inclusion of patients with controlled diabetes in the numerator, making the case that some individuals who are controlled on the current admission for a diabetes-related complication may have been previously hyperglycemic, which contributed to their current state. Lastly, related to Measure 0285: *Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)*, a commenter raised concerns that the denominator may result in unintended consequences. The commenter suggested the measure assess the rate of diabetes-related lower extremity amputations per patients with diabetes, not all discharges.

The Dental Quality Alliance submitted six measures for NQF endorsement, of which two received pre-evaluation comments. The comments addressed the availability of data for dental

carve outs related to Measure 2508: *Prevention-Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk* and Measure 2509: *Prevention- Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk*. The commenter raised the issue of combining EMRs and the integration of third party-data, but noted that if the measures are implemented purely for the assessment of dental quality, then the measures should be supported.

All of these pre-evaluation comments were provided to the Committee prior to its initial deliberations held during the work groups' calls.

Post-evaluation comments

The Draft Report was posted for Member and public comment from June 10, 2014, through July 9, 2014. During this commenting period, NQF received 54 comments from five Member organizations:

Consumers – 0	Professional – 1
Purchasers – 0	Health Plans – 12
Providers – 0	QMRI – 5
Supplier and Industry – 6	Public & Community Health – 30

To facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the August 6th post-comment call. Instead, we will spend the majority of the time considering the measures where consensus was not achieved and the major topics and/or those measures with the most significant issues that arose from the comments. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. ***Please review this table in advance of the call and consider the individual comments received and the proposed responses to each.***

Comments and Their Disposition

Three major themes were identified in the post-evaluation comments, as follows:

1. Socio-Demographic Status
2. Level of Analysis
3. Age Range for Pediatric Dental Measures

Theme 1 – Socio-Demographic Status

Commenters raised concerns about how factors outside of care delivery, such as social determinants of health, can affect access to continual and comprehensive care. There were specific concerns about the evaluated PQI measures: 0272: *Diabetes Short-Term Complications*

Admission Rate (PQI 01); 0274: *Diabetes Long-Term Complications Admission Rate (PQI 03)*; 0281: *Urinary Tract Infection Admission Rate (PQI 12)*; 0285: *Rate of Lower-Extremity Amputation among Patients with Diabetes (PQI 16)*, and 0638: *Uncontrolled Diabetes Admission Rate (PQI 14)* related to reliability. A commenter indicated that factors such as social determinants of health make it difficult to know whether measures are truly reflective of the quality of care being provided.

Regarding Measure 0727: *Gastroenteritis Admission Rate (PDI 16)* and Measure 0728: *Asthma Admission Rate (PDI 14)*, a commenter noted that socioeconomic factors that are unrelated to delivery of care have the potential to affect admissions rates.

While assessing Measure 2528: *Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services*, a commenter highlighted that socioeconomic factors can affect access to comprehensive and continuous dental services, both of which are essential for effective and preventative dental care. The commenter went on to explain that effective and preventative dental care is vital, in that it has the potential to prevent unfavorable physical, behavioral and social health outcomes related to oral health conditions.

> **Proposed Committee Response:** The Committee agrees with the commenters' concerns that social determinants of health, including socio-demographic factors, make it difficult to know whether measures are truly reflective of the quality of care being provided. The Committee urges those who implement these measures to report in a manner that promotes transparency and stratify for socio-demographic factors, as exemplified in the National Healthcare Disparities Report (NHDR) issued by AHRQ.

Theme 2 – Level of Analysis

Overall, the comments received were in support of the recommendations for endorsement of the measures. There were, however, comments about individual components, as well as a group of comments with a common theme related to level of analysis for the following PQI indicators:

- 0272: Diabetes Short-Term Complications Admission Rate (PQI 01)
- 0274: Diabetes Long-Term Complications Admission Rate (PQI 03)
- 0281: Urinary Tract Infection Admission Rate (PQI 12)
- 0285: Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)
- 0638: Uncontrolled Diabetes Admission Rate (PQI 14)

One commenter was concerned about the use for each measure reporting at the clinician or health plan levels, indicating that implementation of the measures may pose problems and thereby affect the reliability of the measures. In addition, the commenter noted that the observed results may vary based on underlying characteristics of the measure population (i.e., social determinants of health) and not adequately reflect the quality of care provided.

> **Proposed Committee Response:** Thank you for your comment. The Committee evaluated the measures as specified by AHRQ, with the level of analysis being at the county, city, or state level. If used at a different level of analysis the measure results may not accurately portray a true quality signal.

Theme 3 – Age Range for Pediatric Dental Measures

Comments received for the pediatric dental measures generally supported recommendations for endorsement of the measures. Commenters noted the measures captured important aspects of continuous and comprehensive dental care. For measures 2508: *Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk*, 2509: *Prevention: Dental Sealants for*

10-14 Year-Old Children at Elevated Caries Risk, 2528: *Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services*, 2511: *Utilization of Services, and Dental Services,* and 2518: *Care Continuity, Dental Services*, some commenters suggested that all children be included because "risk" is not clearly defined. Another commenter expressed concerns that by only including children classified as high risk, children in middle class/middle income homes, who do not always have access to dental care, will be excluded. A commenter also noted it is more important and more cost-effective to monitor sealant utilization trends in children who are classified as moderate to high risk.

Developer Response: Thank you for your support. These measures are a subset of starter pediatric measures that the DQA has developed and approved. The DQA is concurrently working to continually develop additional measures in both pediatric and adult populations. If you would like more information on these, please visit the American Dental Association's website:

http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/Adult_Measures_under_consideration.ash

Proposed Committee Response: Thank you for your comment. The developer can consider these suggestions for future iterations of the measures. The Committee encourages the developer to look at measures across broader population and age ranges in the future.

Measure-Specific Comments

2517: Oral Evaluation, Dental Services

During the evaluation of this measure, the Committee noted that an oral evaluation is a procedure used as a marker to indicate whether children have access to dental care. The Committee questioned why this measure was submitted as an individual measure and not in combination with Measure 2511: *Utilization of Services, Dental Services*, which assesses utilization of dental services. Ultimately, the Committee failed to reach consensus on "Evidence" under the ***Importance*** criterion and unanimously agreed not to vote on Overall Suitability for Endorsement until after the 30-day Member and Public Comment.

NQF received seven post-evaluation comments in strong support of this measure for NQF-endorsement consideration. The commenters indicated the fundamental importance of an oral evaluation for thorough, quality care, citing it as the building block to a plan of care for children's oral health. Other comments highlighted the necessity for this measure to help promote early detection and prevention and the enhancement of the doctor-patient relationship, thereby resulting in better outcomes for not only children, but populations of all ages. Two post-evaluation comments advocated for this measure to be a stand-alone indicator, rather than being combined with Measure 2511: *Utilization of Services, Dental Services*. The commenters acknowledged that Measure 2511 is a better assessment of overall access to dental care, but cautioned that it must be understood that many individuals access care only episodically, when they are in pain or have some other dental problem. They noted that measure 2517 provides a more accurate assessment of access to care because it reflects access to more comprehensive care.

Action Item: The Committee will vote on the measure in an attempt to reach consensus and arrive at a recommendation for or against endorsement.

Developer Response: Thank you for your support. Measure: 2511: *Utilization of Services*, which has been recommended by the NQF review panel for endorsement, reflects the use of dental services and is used as an overall dental health services measures and parallels the annual dental visit HEDIS measure on utilization of dental health services. DQA developed Measure 2517: *Oral Evaluation* specifically to capture the most comprehensive evaluation of urgent, preventive and restorative services. The oral evaluation measure attempts to address several issues, for example, percentage of children who received comprehensive or periodic oral evaluation; variation amongst the stratified groups; disparities; temporal trends and overall impact of the oral evaluation at a population level. Oral evaluation is defined in the CDT procedure code as a thorough evaluation and recording of the extra oral and intraoral hard and soft tissues and requires interpretation if information acquired through additional diagnostic procedures.

Proposed Committee Response: Thank you for your comment. The Committee will review these comments during their deliberations to vote on this measure's overall suitability for endorsement.

2518: Care Continuity, Dental Services

During review of this measure, the Committee questioned whether the measure is truly an assessment of the continuum of care without evidence that clearly substantiates the link. In response, the developer presented two clinical practice guidelines as evidence to support the measure, one from the United Kingdom's National Institute for Health and Care Excellence and one from the American Academy of Pediatric Dentistry,; these guidelines suggest that increased visitation increases the chance for better outcomes. The developer also reiterated that this measure assesses the continuity of care not services received. Ultimately the Committee failed to reach consensus on Evidence under the ***Importance*** criterion and unanimously agreed not to vote on Overall Suitability for Endorsement until after the 30-day Member and Public Comment.

Although in support of this measure, some commenters requested that developer provide more evidence that the measure assessed continuous care. One commenter noted that patients should not go two consecutive years without a follow-up evaluation because undetected oral health conditions could lead to negative health outcomes. Another commenter suggested that the measure be renamed "Two-Year Retention In Care," and went on to explain that retention of patients in care over the span of a two-year period facilitates preventative care, which should result in improved health outcomes and lower treatment costs.

Developer Response: Thank you for your support and comment. Measure 2518: *Care Continuity* seeks to address retention in care over two years and captures whether a child received a comprehensive or periodic oral evaluation in each of two consecutive years. Evidence-based guidelines recommend clinical oral evaluations with a regular recall schedule that is tailored to individual needs based on assessments of existing disease and risk of disease (e.g., caries risk) with the recommended recall frequency ranging from 3 months to no more than 12 months for individuals younger than 18 years of age (National Institute for Health and Care Excellence (NICE), Clinical Guideline 19, 2004). Comprehensive and periodic clinical oral evaluations are diagnostic services that are critical to evaluating oral disease and dentition development. Clinical oral evaluations also are essential to developing an appropriate preventive oral health regimen and treatment plan. Thus, clinical oral evaluations play an essential role in caries identification, prevention and treatment, thereby

promoting improved oral health, overall health, and quality of life. Measure 2518: *Care Continuity* allows plans and programs to identify the effectiveness of efforts to promote an ongoing relationship with their primary dental care provider, improving their receipt of diagnostic services essential to promoting oral and overall health. This measure allows the policy makers to assess the variations in continuity of dental care and disparities amongst different age groups in the pediatric population.

References: National Institute for Health and Care Excellence (NICE). 2004. Clinical Guidelines. "CG19: Dental Recall – Recall Interval between Routine Dental Examinations." Available at: http://guidance.nice.org.uk/CG19.

Proposed Committee Response: Thank you for your comment. The Committee welcomes the developer's response to these comments, and supports changing the name to better reflect measure's intent**.**

2372: Breast Cancer Screening

Commenters generally were supportive of this measure, noting that it is in alignment with current United States Preventive Services Task Force (USPSTF) guidelines. Commenters also supported the measure because it addresses a performance gap in known disparities in care. Commenters also questioned why patient refusal was not an exclusion. Additional comments suggested exclusions for both patient refusal and patients with a terminal diagnosis.

One commenter noted recent evidence that suggests that an annual mammography for women 40 to 59 years of age reduces breast cancer deaths, by a small degree. The commenter suggests that a policy of screening women aged 60 to 69 years every two years may provide the best tradeoff between benefits and harm

Developer Response: NCQA agrees that the measure should focus on the age group (50-74 years) in which there is the strongest evidence for routine screening in women as determined by the U.S. Preventive Services Task Force. The Task Force continues to urge younger women to decide with their clinician when to start screening mammography based on family history and other risk factors. Patient refusal or patient noncompliance are not valid exclusions for HEDIS reporting; therefore, these members should remain in the denominator. It is anticipated that the impact of patient refusal/noncompliance is relatively low and equal across health plans (hence, does not result in bias when comparing results from different organizations).

Proposed Committee Response: The Committee agrees that this measure addresses a high priority area but that patient preference should be documented as an exclusion.