TO: Consensus Standards Approval Committee (CSAC)

FR: Elisa Munthali, Robyn Nishimi, and Mitra Ghazinour

RE: Health and Well-Being Member Voting Results

DA: August 11, 2015

The CSAC will review recommendations from the *Health and Well-Being* project at its August 11 Conference Call.

This memo includes a summary of the project, six recommended measures, and themes identified from and responses to the public and member comments.

Member voting on these recommended measures ended on August 5.

Accompanying this memo are the following documents:

1. **Health and Well-being Draft Report :** The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment table:** Staff has identified themes within the comments received. This table lists 37 comments received and the NQF/Standing Committee's responses.

CSAC ACTION REQUIRED
Pursuant to the CDP, the CSAC may consider approval of recommendations for seven Health and Well-Being candidate consensus standards.

- 0280: Dehydration Admission Rate (PQI 10)
- 1392: Well-Child Visits in the First 15 Months of Life
- 1407: Immunizations for Adolescents
- 1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- 2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
- 2695: Follow-Up after Emergency Department Visit by Children for Dental Caries

Health and Well-being measure not recommended for endorsement:

- 1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)

BACKGROUND

Social, environmental, and behavioral factors can have a significant negative impact on health outcomes and economic stability for individuals and populations. These factors, along with other upstream determinants, contribute up to 60 percent of deaths in the United States—yet only 3 percent of national health expenditures are spent on prevention, while 97 percent are spent on healthcare services. Population health emphasizes factors beyond disease, illness, and clinical care. It includes a focus on health and well-being, prevention and health promotion, and disparities in outcomes and improvement activities within a group and/or among groups. Given its multi-dimensional focus, developing strategies to strengthen the measurement and analysis of health and well-being can best be accomplished using a collaborative approach that includes public health, healthcare delivery systems, and other key sectors whose policies, practices, and procedures influence health. Using the right measures can determine how successful initiatives are in improving population health and help focus future health improvement initiatives in appropriate areas.

NQF convened a Standing Committee of 23 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. Due to the large number of health and well-being measures in NQF's portfolio, maintenance review of endorsed measures and consideration of new measures is taking place through multiple phases. In Phase 1, NQF endorsed 13 health and well-being measures. In Phase 2, the Committee evaluated two newly-submitted measures and five measures undergoing maintenance review. Six measures were recommended for endorsement; one was not recommended. In addition to evaluating the seven measures, the Committee was charged with updating NQF's standard specifications for pneumococcal vaccinations so that they comport with the latest guidelines from the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

DRAFT REPORT

The Health and Well-Being Draft Report presents the results of the evaluation of seven measures considered under the CDP. Six are recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement and one was not recommended. The measures were evaluated against the 2013 version of the measure evaluation criteria.

	MAINTENANCE	NEW	TOTAL
Measures considered	19	2	21
Measures rescheduled for maintenance Review	6	0	6
Withdrawn from consideration	8	0	8
Recommended	4	2	6
Not recommended	1	0	1
Reasons not Recommended	Scientific Acceptability- 1		

COMMENTS AND THEIR DISPOSITION

NQF received four pre-evaluation comments during the pre-evaluation comment period (held March 4-24, 2015), all of which were provided to the Committee prior to the in-person meeting.

The Draft Report went out for Public and Member comment from May 29-June 29, 2015. During this commenting period, NQF received 37 comments from six member organizations and individuals pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Health and Well-being project page under the Public and Member Comment section.

Comment Themes and Committee Responses

At its review of all comments, the Standing Committee had the benefit of developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

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

1. Implementation issues
2. Concerns about measure focus
3. NQF's revised pneumococcal vaccination standard specifications

Theme 1 – Implementation Issues

A number of comments focused on implementation issues and some raised concerns related to other factors that may impact implementation specifically regarding measures 2695: *Follow-Up after Emergency Department Visit by Children for Dental Caries,* 2689: *Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children, and* 0280: *Dehydration Admission Rate (PQI 10).*

A set of two similar comments indicated that measure 2695 would be difficult to implement without relying on self-reported information via follow-up phone calls, a mechanism to track returns to the Emergency Department (ED) for the same reason, or establishment of relationships with a dental network to share patient information. One comment supported this measure and highlighted the importance of measuring follow-up evaluation for vulnerable patients who are at high risk of undetected oral health diseases.

Two similar comments related to measure 2689 questioned whether this measure will apply across health systems or only to Medicaid patients because there is an underlying assumption that emergency department visits for dental caries implies the existence of unaddressed disease. The commenters further indicated that symptoms of severe caries can be treated by antibiotics in a primary or urgent care center. One commenter supported this measure and noted that the measure likely indicates

failures in the health system's to prevent and proactively treat/manage oral health caries in children, which would reduce the frequency of future ED visits.

With regard to measure 0280, one commenter agreed with the endorsement recommendation, but noted that the measure is not widely used by health plans and may be more appropriate for use in non-acute care settings such as nursing homes or long-term care facilities.

Theme 2– Concerns about Measure Focus

Some of the submitted comments raised concerns about the focus of the following measures: Measure 1516: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and Measure 1392: *Well-Child Visits in the First 15 Months of Life.*

A set of two similar comments raised concerns that measure 1392: *Well-Child Visits in the First 15 Months of Life* is too broad and does not assess access to specific services; the commenter recommended that measures specified for age-appropriate immunizations and developmentally appropriate screenings, for example, should be considered during future endorsement processes.

A set of two similar comments agreed with the Committee's inquiry about the rationale of the limited time ranges for measure 1516 and supported further review of an evidence-based scheduling timeframe to increase the applicability of multiple annual well-visits. Another comment did not support the endorsement of this measure because of the rigidity of the 4-year criterion and highlighted the burden that the threshold would have on practices that would need to contact parents to schedule and meet the recommendation for visits through the third-sixth years of life.

Theme 3– NQF Revised Pneumococcal Vaccination Standard Specifications

The six NQF-endorsed pneumococcal vaccination measures are largely aligned with the 2008 NQF standardized specifications. These measures were initially scheduled for endorsement maintenance review in Phase 2; however given the recent revisions to the guidelines, NQF has rescheduled maintenance review. In the interim, NQF updated the standard specifications for pneumococcal vaccination in this phase to enable measure stewards for the existing measures (CMS and NCQA) to assess their measures against revised standardized specifications. One commenter agreed with the revised standards and NQF's decision to reschedule maintenance review for several measures due to the changing pneumococcal vaccination guidelines. Another commenter also supported efforts to revise NQF's standard specifications for pneumococcal vaccination for immunocompromised individuals across both age groups; however, the commenter cautioned that, in the absence of a national immunization administration database, there is potential risk for repeat vaccinations. Additionally the commenter noted that one of the vaccinations is cost-prohibitive, which may penalize physicians and other clinicians who care for underserved, low income populations. Lastly, the commenter noted that exceptions should be made for patients with limited life expectancy (e.g., exclusion of hospice patients).

NQF MEMBER VOTING RESULTS

Health and Well-Being Member Voting Results will be available to both the public and the CSAC in an addendum shortly after the Member Voting Period ends on August 5, 2015 6pm ET.

REMOVE ENDORSEMENT OF MEASURES

Eight measures previously endorsed by NQF have not been re-submitted or have been withdrawn from maintenance of endorsement consideration:

Measure	Description	Reason for removal of endorsement
0617: High Risk for Pneumococcal Disease - Pneumococcal Vaccination	The percentage of patients aged 2 through 64 with a high risk condition, or aged 65 years and older who either received a pneumococcal vaccine (reported separately) or had a contraindication to pneumococcal vaccine (reported separately).	The measure steward elected to retire the measure's endorsement.
1388: Annual Dental Visit (ADV)	Percentage of patients 2-21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.
1396: Healthy Physical Development by 6 Years of Age	The percentage of children 6 years of age who had healthy physical development services. The measure has four rates: BMI Assessment, Physical Activity Counseling, Nutrition Counseling and Screen Time Counseling.	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.
1397: Sudden Infant Death Syndrome Counseling	The percentage of children 6 months of age who had Sudden Infant Death Syndrome (SIDS) counseling.	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.
1399: Developmental Screening in the First Three Years of Life	The percentage of children ages one, two and three years who had a developmental screening performed.	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.
1419: Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care	Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary	The measure submission was not in compliance with NQF's "conditions for consideration."

Measure	Description	Reason for removal of endorsement
Medical Providers	Care Medical Providers	
1512: Healthy Physical Development by 13 Years of Age	Healthy Physical Development by 13 Years of Age	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.
1514 : Healthy Physical Development by 18 Years of Age	The percentage of children 18 years of age who had healthy physical development services. The measure has four rates: BMI Assessment, Physical Activity Counseling, Nutrition Counseling and Screen Time Counseling	The measure steward elected to retire the measure's endorsement because of poor uptake in the use of the measure.

Appendix A-Measure Evaluation Summary Tables

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

0280: Dehydration Admission Rate (PQI 10)—Recommended
Submission |
Description: Admissions with a principal diagnosis of dehydration per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions. Numerator Statement: Discharges, for patients ages 18 years and older, with either a principal ICD-9-CM diagnosis code for dehydration; or any secondary ICD-9-CM diagnosis codes for dehydration and a principal ICD-9-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury. [NOTE: By definition, discharges with a principal diagnosis of dehydration, hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury cannot have an assignment of MDC 14 (pregnancy, childbirth and the puerperium). Thus, obstetric discharges are not considered in the PQI rate. See Prevention Quality Indicators technical specifications for additional details and in the supporting information. Denominator Statement: Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred. Exclusions: Not applicable Adjustment/Stratification: Level of Analysis: Population : County or City, Population : National, Population : Regional, Population : State Setting of Care: Hospital/Acute Care Facility Type of Measure: Outcome Data Source: Administrative claims Measure Steward: Agency for Healthcare Research and Quality
STANDING COMMITTEE MEETING 04/22/2015 **Note: Importance to Measure and Report was evaluated in Health and Well-Being Phase 1 1. Importance to Measure and Report: **The measure meets the Importance criterion.** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: Y-15; N-3; 1b. Performance Gap: H-6; M-12; L-0; I-1 Rationale: • Committee members questioned the continued use of this measure for quality improvement by highlighting changes in coding and the traditional treatment care setting for dehydration from inpatient to ambulatory or ED observation units. While the developer acknowledged the shift towards observation care and improved ED management of dehydration, subsequent analyses could not quantify the extent to which these changes obviated the need for the measure.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion. **Note: Reliability was evaluated in Health and Well-Being Phase 1 (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-3; M-15; L-0; I-1 2b. Validity: H-4; M-13; L-1; I-0 Rationale: • The Committee noted inconsistencies with the measure's title and description. While the title specifically mentions dehydration, measure specifications also include adult gastroenteritis diagnosis and billing codes. • The developer used the State Emergency Department Database (SEDD) and the State Ambulatory Surgery

0280: Dehydration Admission Rate (PQI 10)—Recommended

and Services Databases (SASD) to assess the observed decrease in inpatient hospitalization from 2006-2009 with a principal diagnosis of dehydration (24.5% decrease) and 2009-2012 (26.0% decrease). The developer also observed an increase in observation services with dehydration as a first listed diagnosis from 2006 to 2009 (29.6% increase) and less drastic increase between 2009 and 2012 (17.7% increase. However, further analysis found that PQI 10 rates (all Inpatient) are "moderately" correlated with rates of observation services for dehydration. This suggests that the relationship between inpatient stays for dehydration and outpatient services is not consistent across counties (e.g., counties with low inpatient rates have high rates of observation services for dehydration).

- The developer used these same data sets to test if substitution of observation services is replacing treatment of less complicated cases. The developer found only a marginal increase (10 percent) in the number of medical comorbidities in the medical records.
    - The developer's analysis revealed that 95 percent of the numerator accounts included individuals with a principle diagnosis of dehydration, as well as those with a principle diagnosis of acute renal failure, hypernatremia, and gastroenteritis.
    - The developer will consider whether to revise specifications to include a secondary diagnosis of dehydration.

3. Feasibility: H-15; M-4; L-0; I-0

**Note: Feasibility was evaluated in Health and Well-Being Phase 1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The data elements are routinely generated and used during care delivery.
- All data elements can be found in defined fields in electronic claims.

4. Usability and Use: H-3; M-10; L-6; I-0

**Note: Usability and Use and Use was evaluated in Health and Well-Being Phase 1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The Committee identified overuse of dehydration care that takes place in the emergency department setting as a potential unintended consequence of this measure.
- This measure is currently in use for the CMS, Medicare Fee For Service Physician Feedback Program / Value-Based Payment Modifier, Quality and Resource Use Reports (QRUR).

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-18; N-0

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:

- Two comments were submitted for this measure. One comment indicated that admitting patients in hyperosmolar states demonstrates good care. Another comment agreed with the Committee's endorsement recommendation, but cautioned that the measure is not widely used by health plans and may be more appropriate for use in non-acute settings such as nursing homes or long-term care facilities. The comment also noted that dehydration is often a symptom of an underlying disease or condition and questioned the true value of using this measure to compare performance across facilities.

NQF response:

- NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the

0280: Dehydration Admission Rate (PQI 10)—Recommended
Standing Committee during the Post-Comment meeting. Developer response: • The purpose of the PQIs is to identify potentially preventable hospitalization. In the case of dehydration, hospitalizations may be preventable through access to community based care for high risk patients to prevent dehydration, identify and treat dehydration early before it requires hospitalization or proactive interventions for individuals at very high risk for dehydration (e.g. post gastrointestinal surgery). The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. The PQI are not designed to identify "inappropriate" hospitalizations, nor to imply that the hospitalizations captured are mild enough to be treated in an ambulatory setting. Many of the hospitalizations captured by the PQI are clinically indicated. The preventability is further upstream, before a patient develops a severe clinical state requiring hospitalization. • The PQI 10 indicator for dehydration was developed to provide insight into the community health care system or services outside the hospital setting. Even though there is a wide spectrum of underlying conditions related to dehydration, there is evidence that with high-quality, community-based primary care, a portion of hospitalizations can be avoided. The indicator is defined, tested, validated and endorsed at the geographic area (county and larger) level. The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. In 2009 AHRQ explored alternative specifications of the PQI which would measure quality and access to care for health plan populations or large physician groups (Davies et al, 2011, Med Care 49(8)). Incidentally, the panels recommended that the "dehydration" be adapted to measure quality of care for long term care facilities. However, AHRQ has not, tested or otherwise implemented the alternative specifications for health plans, large physician groups or long-term care facilities as part of the AHRQ QI program.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1392: Well-Child Visits in the First 15 Months of Life—Recommended
Submission |
Description: The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life. Numerator Statement: Children who received the following number of well-child visits with a PCP during their first 15 months of life: - No well-child visits - One well-child visit - Two well-child visits - Three well-child visits - Four well-child visits - Five well-child visits - Six or more well-child visits Denominator Statement: Children 15 months old during the measurement year. Exclusions: None Adjustment/Stratification: Level of Analysis: Health Plan, Integrated Delivery System Setting of Care: Ambulatory Care : Clinician Office/Clinic Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING 04/22/2015 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: H-2; M-14; L-3; I-0; IE-0; 1b. Performance Gap: H-9; M-11; L-0; I-0 Rationale: • The evidence supporting the measure is based on two clinical practice guidelines from the American Academy of Pediatrics (AAP) and Bright Future, both of which derive their evidence from expert consensus and not a systematic review of the evidence. • Committee members also expressed concern about the measure's focus on confirmation of well-child visits instead of services provided during the visits. The Committee questioned why the measure specifications do not include specific care processes. The developer explained that the measure assesses the number of visits within the measurement year for children aged 0 to 15 months, and therefore it is a proxy for access to care. • The measure is specified for six visits; however the guidelines recommend eight visits. The developer explained that the number of visits is aligned with the AAP periodicity chart, which recommends six visits. • The Committee struggled to highlight an opportunity for improvement since the average performance for commercial plans is 78.04 percent and 61.57 percent for Medicaid plans (2014). The developer noted opportunities for improvements within commercial plans and Medicaid plans, exemplified by a significant gap between the 10th and 90th percentiles.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion. (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-10; M-10; L-0; I-0 2b. Validity: H-11; M-9; L-0; I-0

1392: Well-Child Visits in the First 15 Months of Life—Recommended

Rationale:

- Utilizing beta-binomial testing, the developer provided measure score reliability for six or more visits. These data were derived from all plans submitting data to NCQA for HEDIS in 2014 (396 commercial plans and 175 Medicaid plans). No reliability data were provided for visits 0 through 5.
- The Committee debated if there could be variation in the performance gap among the individual number of visits and discussed whether stratification by the individual number of visits (ranging from 0 to 6) would improve the reliability of the measure.
- Committee members requested that the developer submit additional testing that includes measure score reliability for well-child visits ages 0 through 5 within one year. NCQA is willing to update the reliability testing, but given NQCA's three to four year review cycle, one year might not be enough time to update the measure.
- Some Committee members questioned the validity of the measure when well-child visits are combined with other visits, such as sick visits.
    - A Committee member confirmed that the measure contains a coding modifier that allows reporting of a well-child visit and a sick visit to occur concurrently - during the same visit.
    - Additionally, the developer offers a policy clarification support system that allows those reporting on the measure to call trained staff to confirm what qualifies as a well-child visit.

3. Feasibility: H-15; M-5; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data elements are collected through administrative claims, electronic clinical data, and/or paper records. NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.

4. Use and Usability: H-15; M-5; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, and the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-19; N-1

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:

- A set of four similar comments submitted on this measure raised concerns that it is too broad and does not adequately assess access to specific services. The comments noted that measures specified for age-appropriate immunizations and developmentally appropriate screening should be considered in the future. Two comments supported the Committee's recommendation for endorsement.

NQF response:

- NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting.

1392: Well-Child Visits in the First 15 Months of Life—Recommended
Developer response: • This measure assesses whether or not children up to the age of 15 months old received the recommended number of well-child visits with their primary care provider. The measure is based on guidelines (AAP/Bright Futures) and evidence that children should be seen by their provider on a regular basis so they can receive the appropriate assessments such as initial/interval medical history, measurements (length/height and weight, head circumference, and weight for length), behavioral assessment, physical examination, immunization and anticipatory guidance.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1407: Immunizations for Adolescents—Recommended
Submission |
Description: The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday. Numerator Statement: Adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Denominator Statement: Adolescents who turn 13 years of age during the measurement year. Exclusions: Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered. Either of the following meet exclusion criteria: • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday. • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011. Adjustment/Stratification: Level of Analysis: Health Plan, Integrated Delivery System Setting of Care: Ambulatory Care : Clinician Office/Clinic Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING 04/22/2015 1. Importance to Measure and Report: **The measure meets the Importance criterion.** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: H-9; M-7; L-0; I-0; IE-0; 1b. Performance Gap: H-15; M-2; L-0; I-0 Rationale: • The Committee cited strong evidence that is supported by CDC/ACIP guidelines. The ACIP guidelines for meningococcal, tetanus, diphtheria, and pertussis vaccines recommend vaccination for all children ages 11 and 12 years.

1407: Immunizations for Adolescents—Recommended

- Some Committee members suggested that the developer replace Td (tetanus toxoid only) with Tdap (tetanus, diphtheria, and pertussis).
- Committee members highlighted performance gaps between different types of health plans (e.g., Medicaid versus commercial).

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-15; M-2; L-0; I-0 2b. Validity: H-13; M-4; L-0; I-0

Rationale:

- There was general confusion about the inclusion of both a Td and Tdap. Some Committee members speculated that this may reflect the transition from Td to a newer Tdap vaccine. The CDC/ACIP and the Academy of Family Practice have not yet recommended Tdap only, and therefore Td will continue to be included in the measure specifications.
- The developer conducted beta-binomial reliability testing at the measure score level—i.e., a signal to noise analysis, where the reliability of the measure is represented as the ratio of signal (variation due to a health plan's performance) to noise (variation due to measurement error). The reliability scores for commercial plans (HMO and PPO combined) ranged from 0.99-1.00. The reliability score of Medicaid Plans (HMO only) was 0.98. The Committee agreed that the reliability testing and results were adequate.
- The developer tested the validity of the measure using empirical validity data and a systematic assessment of face validity of the performance measure score. Performance on this measure was correlated to Tdap measure and to the measure Human Papillomavirus Vaccine (HPV) for Female Adolescents. For the Tdap measure, the developer noted a Pearson's coefficient of 0.79 and 0.66 for commercial and Medicaid plans, respectively. For the HPV measure, the observed Pearson's coefficients ranged from 0.37-0.46 for Medicaid plans, and 0.49-0.55 for commercial plans. The Committee agreed that the validity testing and results were adequate.
- The Committee did not identify any threats to validity.

3. Feasibility: H-14; M-3; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- All of the required data elements are routinely generated and used during care delivery and are available in electronic form (administrative data from billing records).
- NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.

4. Usability and Use: H-16; M-1; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.

5. Related and Competing Measures

- No related or competing measures noted.

1407: Immunizations for Adolescents—Recommended
Standing Committee Recommendation for Endorsement: Y-17; N-0
6. Public and Member Comment: **May 29, 2015 – June 29, 2015** Comments received: • This measure received four comments, all supporting the Committee's recommendation of endorsement for the measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life—Recommended
Submission |
Description: The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. Numerator Statement: Children who received at least one well-child visit with a PCP during the measurement year. Denominator Statement: Children 3-6 years of age during the measurement year. Exclusions: None Adjustment/Stratification: Level of Analysis: Health Plan, Integrated Delivery System Setting of Care: Ambulatory Care : Clinician Office/Clinic Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING 04/22/2015 1. Importance to Measure and Report: **The measure meets the Importance criterion.** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: H-1; M-4; L-5; I-1; IE-8; 1b. Performance Gap: H-10; M-10; L-0; I-0 Rationale: • The measure is based on the AAP and Bright Futures guidelines, which recommend at least four well-care visits for children 3-6 years of age. • The Committee acknowledged that child-well visits are good clinical practice, but questioned whether existing evidence supports the link between well-child visits during ages 3 to 6 and better health outcomes. The measure assesses the frequency of visits, rather than the care and services provided during those visits. • Several Committee members contemplated whether 6-year olds should be included in the measure without evidence to support their inclusion. One Member noted that 6-year olds typically receive environmental screenings in school. • Following detailed review of the guidance for evaluating the clinical evidence, the Committee decided to apply the "insufficient evidence with exception" option, agreeing that it was appropriate to hold providers accountable for performance in the absence of empirical evidence of benefit to the patient.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion. (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life—Recommended

2a. Reliability: H-10; M-8; L-0; I-2 2b. Validity: H-8; M-9; L-3; I-0

Rationale:

- Committee members asked clarification on the numerator time window, where a child has a visit at 4 years and 1 month and 4 years and 11 months but does not have a visit at 5 years. The developer explained that multiple visits during a single year of life do not count towards visits in a future year of life; therefore, the visit at 4 years and 11 months would not count as a 5-year visit.
- The developer conducted beta-binomial reliability testing at the measure score level—i.e., a signal to noise analysis, where the reliability of the measure is represented as the ratio of signal (variation due to a health plan's performance) to noise (variation due to measurement error). Observed Pearson's coefficient results for plans in the 10th percentile were between 0.7 and 0.9 for the majority of plans. The Committee agreed that the reliability testing and results were adequate.
- The developer used both face validity and empirical data to test construct validity. Performance on well-child visits was correlated to the measure *Children and Adolescents' Access to Primary Care Practitioners* (children under the age of 24 months who had the recommended number of preventive care visits [8 visits total]. This measure is not in NQF's portfolio.) Commercial plan results positively correlated with the Pearson's coefficient of 0.80; for Medicaid plans the Pearson's coefficient was of 0.65. All correlations were statistically significant, with a p-values < 0.05. The Committee agreed that the validity testing and results were adequate.

3. Feasibility: H-17; M-3; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Data are collected through administrative claims, electronic clinical data, and/or paper records and the developer anticipates that as electronic health records become more widespread, the reliance on paper record review will decrease.
- NCQA conducts independent audits to ensure that HEDIS specifications are met. The following functions are assessed: information practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, analytic file production, and reporting and documentation.

4. Usability and Use: H-11; M-7; L-2; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This measure is currently in use for public reporting of health plan data. These programs include NCQA's Annual State of Health Care Quality and Quality Compass, the Medicaid Child Core Set, the Health Insurance Marketplace Quality Rating System. The measure is also a component of the CMS Core Measures.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-16; N-4

6. Public and Member Comment**: May 29, 2015 – June 29, 2015**

Comments received:

- A set of two similar comments affirmed the Committee's concerns about the rationale of the limited time ranges. The commenter also supported further review of an evidenced-based scheduling timeframe to increase the applicability of multiple annual well-visits. The commenter further noted that measures such as verification of school-entry immunizations may be a better way to measure access to care. While an

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life—Recommended
additional comment supported this measure, another comment did not support endorsement of this measure because of the rigidity of the 4-year criterion and noted that this threshold becomes a burden on practices that would need to contact parents to schedule and meet the recommendation for visits through the third-sixth years of life. NQF response: • NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting. Developer response: • This measure assesses whether or not children ages 3 to 6 years old received the recommended number of well-child visits with their primary care provider. This measure is based on AAP/Bright Futures guidelines that children ages 3 to 6 years old should be seen by their provider once per year to get the appropriate assessments. Appropriate assessments recommended by the guidelines include getting a medical history, getting a vision and hearing screening, conducting a surveillance of development, doing a behavioral/psychosocial assessment, conducting a physical examination, administering immunizations, assessing oral health and providing anticipatory guidance. You're correct that a visit at 4 years and 11 months would not count as a 5-year visit because the child should be seen again in their 5th year of life, even if it's later in the year.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children—Recommended
Submission |
Description: Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children Numerator Statement: Number of ED visits with caries-related diagnosis code among all enrolled children Denominator Statement: All member months for enrollees 0 through 20 years during the reporting year divided by 100,000. NOTES: 1. Age range is 0 through 20 years (<21 years) to coincide with Medicaid Early and Periodic Screening, Diagnostic, and Treatment eligibility. (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html). 2. 100,000 member months of enrollment was selected instead of a per population approach due to enrollment variation. This is consistent with the approach that the Centers for Medicare and Medicaid Services has taken for the Medicaid Adult Health Care Quality measures of potentially preventable hospitalizations, which measures rates per 100,000 member months (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html) Exclusions: The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits. Adjustment/Stratification: Level of Analysis: Integrated Delivery System Setting of Care: Emergency Medical Services/Ambulance Type of Measure: Outcome Data Source: Administrative claims

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children—Recommended

Measure Steward: American Dental Association in behalf of the Dental Quality Alliance

STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: **The measure meets the Importance criterion.**

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: Y-20; N-1; 1b. Performance Gap: H-12; M-6; L-2; I-1;

Rationale:

- The Committee contested the strength of presented evidence that linked prevention to caries-related emergency department (ED) visits. Data were presented from both the Texas Medicaid Program, which ranks among the highest for utilization of preventive dental services, and the Florida Medicaid Program, which ranks among the lowest. For these two programs, the measure shows an inverse relationship between use of preventive dental services and ED visits. Specifically, the Florida Medicaid program reported 2.5 times more ED visits than the Texas Medicaid program.
- Committee members debated whether this measure assessed availability and accessibility of preventive services, appropriateness of utilization, or under-utilization of appropriate oral care at the primary care level.
- The developer explained that high rates of ED visits reflect failures in outpatient management and care. The measure focuses specifically on caries-related visits to the ED because the frequency of these visits can be influenced by outpatient management and prevention, along with early identification of caries and disease management.
- Committee members noted that claims data from both the ED and dental office should be collected since the measure tracks follow-up care in individual patients. (These two settings traditionally use separate billing systems.) The developer explained that the measure is specified for Medicaid programs only. These programs have access to both medical and dental claims at the individual patient level and will be able to track follow-up visits within specified timeframe.
- The measure submission form indicates "integrated delivery system" as the level of analysis. The Committee raised concerns about endorsing this measure at the current level of analysis. The developer concurred, and noted that the primary measure focus is Medicaid programs. To minimize confusion, the developer and NQF will work together to ensure the appropriate level of analysis is selected from the NQF taxonomy selection.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-7; M-11; L-1; I-2 2b. Validity: H-6; M-14; L-1; I-0

Rationale:

- The developer tested validity at the data element level only. This is sufficient to meet NQF's testing requirements; additional reliability testing of the same data elements is not required.
- The developer evaluated agreement between the claims data and 300 ED records at one Florida ED by calculating the sensitivity, specificity, positive and negative predictive value, and kappa statistic. The 300 records of patients 0-20 years old were randomly selected for data abstraction. Other selection criteria included Medicaid payer type and those with a non-traumatic ED visit related to the oral cavity. Two emergency medicine physicians reviewed the records. Overall agreement was 87.7 percent, indicating high overall concordance between the administrative claims and ED records. The kappa statistic was 0.71. Sensitivity was 82 percent and specificity was 90 percent. The positive predictive value was 79 percent and negative predictive value was 92 percent. The Committee agreed that validity testing and results were adequate.
- The Committee asked the developer whether people utilized EDs due to convenience or lack of access to primary care. With the exception of rural communities with lower on provider numbers, the developer

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explained indicated that the main issue is the number of providers available to individuals who receive dental care via Medicaid. • The Committee cautioned that the measure could show supply-driven and or process-driven access problems. The developer reiterated that the measure is intended to assess the severity of the disease unaddressed through any care mechanism.
3. Feasibility: H-12; M-9; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • This measure relies on standard administrative data fields commonly used for a wide range of billing and reporting purposes. All required data elements are defined in electronic claims. • This measure is intended for widespread adoption and is designed to eliminate software or other proprietary issues that would require licensing fees. The measure specifications will be accessible through a website and can be used free of charge for non-commercial purposes.
4. Usability and Use: H-10; M-10; L-0; I-1 *(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)* Rationale: • The Committee acknowledged that implementation of this measure is a critical first step to encourage states to measure the number of ED visits with caries-related diagnosis code among all enrolled children in Medicaid programs. • Before expanding the measure to other care settings, the Committee suggested that the developer pilot the measure to learn about any potential unintended consequences.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Y-20; N-1
6. Public and Member Comment**: May 29, 2015 – June 29, 2015** Comments received: • This measure received seven comments. The majority of the comments supported the Committee's recommendation to endorse the measure. A set of two similar comments pointed to the underlying assumption that emergency department visits for dental caries implies unaddressed disease and requested that the developer should specifically define how they intend to assess the severity of the unaddressed disease through any care mechanism. NQF response: • NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting. Developer response: • Caries-related ED visits are ambulatory sensitive condition visits (e.g., they are potentially preventable). These visits signify a failure of the ambulatory oral healthcare system to prevent and proactively treat and manage dental caries in children. Children receive symptomatic relief in ED settings (antibiotics and pain medication), but they do not receive definitive care that addresses the underlying disease process. Significantly, these ED visits can be reduced through evidenced-based processes of care delivered in outpatient ambulatory settings. • This measure was developed and tested for implementation at the Medicaid program (or equivalent) level. The DQA appreciates the support for this measure and interest in applications for other delivery system levels. The DQA's measures development efforts are ongoing, and opportunities to adapt this measure for application at other levels will be considered.

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children—Recommended
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries—Recommended
Submission |
Description: Percentage of ambulatory care sensitive Emergency Department (ED) visits for dental caries among children 0 – 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit. Numerator Statement: Number of ambulatory care sensitive ED visits by children for dental caries for which the member visited a dentist within (a) 7 days (NUM1) and (b) 30 days (NUM2) of the ED visit Denominator Statement: Number of ambulatory care sensitive ED visits by children 0 through 20 years for dental caries in the reporting period. Note: Age range is 0 through 20 years (<21 years) to coincide with Medicaid Early and Periodic Screening, Diagnostic, and Treatment eligibility. (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html). Exclusions: The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits. Adjustment/Stratification: Level of Analysis: Integrated Delivery System Setting of Care: Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance Type of Measure: Process Data Source: Administrative claims Measure Steward: American Dental Association on behalf of the Dental Quality Alliance
STANDING COMMITTEE MEETING 04/22/2015 1. Importance to Measure and Report: **The measure meets the Importance criterion.** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: H-0; M-11; L-5; I-4; IE-0; 1b. Performance Gap: H-3; M-12; L-4; I-1 Rationale: • The Committee was concerned that the measure holds health plans accountable for follow-up visits without consideration of other attributing factors like access barriers. The developer reiterated that the measure is not intended for use by health plans; it is intended to assess the relationship between care processes and access to care at the Medicaid program level. • The measure is based on 12 studies that provided the following evidence statements: 1) Definitive care is not provided to children presenting with pain and/or swelling in an emergency department for dental caries-related reasons; 2) Definitive dental care is necessary to treat the disease but often is not received; and 3) Non-traumatic visits to an ED for dental problems by children (initial and repeat visits) are a resource burden for state Medicaid programs. • The Committee examined the adequacy of the evidence linking follow-up visits at seven and 30-days after caries-related ED encounters to better health outcomes. The developer presented data that showed that shorter time intervals between ED and follow-up visits increased the probability that the next encounter would result in an outpatient visit instead of an ED visit.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion.

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries—Recommended

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-3; M-10; L-7; I-0 2b. Validity: H-2; M-13; L-5; I-0

Rationale:

- The absence of CDT codes for specified services made it difficult for the Committee to assess the impact of follow-up visits on health outcomes. The developer confirmed that the intent of the measures is to assess access to follow-up care. The developer conducted a thorough analysis to ensure the inclusion of wide range of services in the numerator, including identifying patterns for CDT coding for the wide variation of services performed during follow-up visits per patient need
- The developer tested validity at the data element level; therefore reliability testing is not required by NQF.
- The developer assessed critical data element validity at a Florida facility using 300 records, and face validity was used to test supplemental data. The testing assessed the accuracy of: 1) the proposed diagnosis code set to identify caries-related ED visits; and 2) CDT codes to identify dental services as the data elements that contribute most to the measure score. The Kappa statistic was 0.71. Sensitivity was 82 percent, and specificity was 90 percent. Positive predictive value and negative predictive value were 79 and 92 percent, respectively.

3. Feasibility: H-9; M-8; L-2; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- All of the required data elements are routinely generated and used during delivery of care and are available in electronic form (administrative claims).
- This measure is intended for widespread adoption and is designed to avoid using software or other proprietary materials that would require licensing fees. The measure specifications will be accessible through a website and can be used free of charge for non-commercial purposes.

4. Usability and Use: H-6; M-9; L-4; I-1

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- This is a new measure and is not in current use. The developer specified that planned use includes: public reporting and quality improvement with external benchmarking to multiple organizations.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-13; N-7

6. Public and Member Comment: **May 29, 2015 – June 29, 2015**

Comments received:

- This measure received seven comments. The majority of the comments supported the Committee's recommendation to endorse the measure. A set of two similar comments raised concerns by noting that this measure would identify gaps in follow-up care, but the commenters felt that the measure is impossible to operationalize without relying on self-report via follow-up phone calls, tracking of returns to the ED for same reason, or establishment of relationships with a dental network to share patient information.

NQF response:

- NQF has reviewed your comment and appreciates your input. Your comment was acknowledged by the Standing Committee during the Post-Comment meeting.

Developer Response:

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries—Recommended
• This measure was developed and tested for implementation with Medicaid program integrated medical-dental administrative enrollment and claims data or equivalent integrated medical-dental data. Feasibility and validity testing demonstrated that this measure could be reliably operationalized with linked medical-dental administrative claims. Organizations that do not have linked medical-dental data would not report this measure. Identifying follow-up care using dental procedure codes is consistent with other previously endorsed program-level dental process of care measures and would not require patient self-report or other additional mechanisms to identify dental services. • This measure was developed and tested for implementation at the Medicaid program (or equivalent) level. The DQA appreciates the support for this measure and interest in applications for other delivery system levels. The DQA's measures development efforts are ongoing, and opportunities to adapt this measure for application at other levels will be considered.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals