Health and Well-Being, Phase 2

FINAL REPORT

November 16, 2015

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0008

NATIONAL QUALITY FORUM

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Health and Well-Being, Phase 2

Executive Summary

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 to as many as 60 percent of deaths in the United States.[1] Yet only 3 percent of national health expenditures are spent on prevention, while 97 percent are spent on healthcare services.[2]

Population health emphasizes factors beyond disease, illness, and clinical care. It focuses on health and well-being, prevention and health promotion, and disparities in outcomes and improvement activities within a group and/or among groups. Strengthening the measurement and analysis of health and well-being requires a collaborative approach with input from public health, healthcare delivery systems, and other 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.

The 23-member Health and Well-Being Standing Committee oversees the NQF Health and Well-Being Portfolio. This includes evaluating newly submitted and previously endorsed measures against NQF's standard measure evaluation criteria and supplemental population health-related guidance; identifying gaps in the portfolio; providing feedback on how the portfolio should evolve over time; and serving on any ad hoc or expedited projects in designated topic areas.

The Committee is conducting maintenance review of endorsed measures and is considering new measures in three phases because of the large number health and well-being measures. This report is the second of three. In phase 1, NQF endorsed 13 health and well-being measures.

In phase 2, the Standing Committee evaluated 2 newly submitted measures and 5 measures undergoing maintenance review. Six measures were recommended for endorsement; 1 was not recommended. The 6 measures recommended by the Standing Committee are:

- 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

The Committee did not recommend the following measure:

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

Brief summaries of the measures reviewed in phase 2 are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

In addition to evaluating the 7 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.

Introduction

Social, environmental, and behavioral factors can have a significant negative impact on individual and population health outcomes, as well as affect a community's economic stability. Although quality improvement and measurement overwhelmingly have focused on clinical care and healthcare delivery, evidence documents that effective programs and policies that promote health can prevent disease, increase productivity, and yield billions of dollars in savings for the U.S. healthcare system. With the right measures and a collaborative approach with key stakeholders whose policies, practices, and procedures influence health and healthcare, improvement in the health and well-being of individuals and communities has the potential to effectively and significantly reduce mortality and excess morbidity.

Health and Well-Being in Three Phases

The Health and Well-Being Standing Committee is conducting maintenance review of endorsed measures and is considering new measures in 3 phases because of the large number health and well-being measures. This report is the second of 3. In phase 1 (2014), NQF endorsed 13 measures. The Health and Well-Being phase 1 report provides details on these measures, as well as the methods and approach that NQF has taken in the first 2 phases of the Health and Well-Being Project.

National Quality Strategy, National Prevention Strategy, and NQF's Health and Well-Being Portfolio of Measures

NQF's work in health and well-being emphasizes alignment with the National Quality Strategy (NQS)[3] and National Prevention Strategy (NPS) of the Department of Health and Human Services (HHS).[4] The NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, state, and national) to improve the quality of healthcare in the United States. It established the 3-part aim of better care, affordable care, and healthy people/communities, focusing on 6 priorities to achieve those aims: Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care. The NPS serves as the overarching framework for improving the quality of life for individuals, families, and communities by shifting the nation's focus from sickness and disease to prevention and wellness. It established 4 strategic directions to guide actions with demonstrable health improvement efforts: Healthy and Safe Community Environments, Clinical and Community Preventative Services, Empowered People, and Elimination of Health Disparities.

Improvement efforts for subtopics within NQF's Health and Well-Being Portfolio—Community-Level Indicators of Health and Disease, Primary Prevention and/or Screenings, and Oral Health Care—align with the NQS and NPS priority areas and strategic directions, as do the measures considered in this phase, as described below.

Best Practices for Healthy Living

The Committee reviewed 2 oral health and dental care measures, which relate to the goal of healthy living. Early childhood dental caries are among the most prevalent diseases found in children in the United States; as of 2011, 42% of children ages 2 to 11 had dental caries in primary teeth.[5] Emergency

department (ED) visits related to dental caries use scarce ED resources and also are a financial burden. During 2012, dental caries-related ED visits for individuals 21 years of age and younger cost an average of $564 per visit and $104.2 million overall.[6]

Measure #2689, Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children, assesses the rate of caries-related ED visits, while measure #2695, Follow-Up after Emergency Department Visit by Children for Dental Caries, assesses whether children have access to follow-up care within 7 days (and also within 30 days) after the ED visit.

Effective Prevention and Treatment of Illness/Clinical and Community Preventive Services

The NQF portfolio includes measures that support preventive services, as envisioned by both the NQS and NPS. These measures assess immunizations (measure #1407: Immunizations for Adolescents) and well-child visits (measure #1392: Well-Child Visits in the First 15 Months of Life and measure #1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life).

Well-child visits, in particular, are key prevention leverage points. They focus on prevention and offer an opportunity to monitor children's health and provide immunizations, as well as assess a child's growth and development, including vision and hearing testing. Despite high rates of overall primary care physician access, the number of children with well-child visits remains below the number recommended by the American Academy of Pediatrics and Bright Futures guidelines.[7]

Moreover, other sociodemographic disparities persist. The National Health Interview Survey reports that Hispanic children are less likely than white and black/African American children to receive a well-child visit. In 2013, 86% of Hispanic children received a well-child visit, compared with 92% of white and black/African American children.[8] Children who were uninsured or had only public insurance were less likely to have a well-child visit, compared to children with private insurance. According to the National Committee for Quality Assurance (NCQA), on average, performance improved for commercial health plans between 2012 and 2014 (77.09% to 78.04%), while performance for Medicaid health plans remains poorer and uneven (61.67% in 2012, 63.60% in 2013, and 61.57% in 2014).[9]

NQF Portfolio of Performance Measures for Health and Well-Being

Currently, NQF's portfolio of health and well-being measures includes measures for Health-Related Behaviors and Practices to Promote Healthy Living; Community-Level Indicators of Health and Disease; Modifiable Social, Economic, and Environmental Determinants of Health; Oral Health; and Primary Prevention and/or Screening. The portfolio encompasses 62 measures: 38 process measures, 22 outcome measures, 1 structural measure, and 1 composite measure (see table below). During this phase of work of these measures were evaluated by the Health and Well-Being Standing Committee. As previously noted 13 measures were endorsed in phase 1. Due to the high volume of measures in the portfolio, as well as NQF's cyclical measure review process (based on a harmonization analysis and most recent endorsement date), the Committee will evaluate remaining measures at a later date, along with any newly submitted measures.

Table 1. NQF Health and Well-Being Portfolio of Measures

	Process	Outcome	Structural	Composite
Health-Related Behaviors and Practices to Promote Healthy Living	2	2	0	0
Community-Level Indicators of Health and Disease	1	9	1	1
Modifiable Social, Economic, and Environmental Determinants of Health	5	9	0	0
Oral Health	5	2	0	0
Primary Prevention and/or Screening	25	0	0	0
Total	**38**	**22**	**1**	**1**

NQF has assigned some measures related to health and well-being to other projects, primarily to manage the size of the portfolio and take advantage of technical expertise. For example, the endocrine project reviewed measures that assess osteoporosis screening, and the infectious disease project reviewed measures for HIV/AIDS screening.

Endorsement of measures by NQF is valued not only because the evaluation process is both rigorous and transparent, but also because multistakeholder committees conduct the evaluations. These committees are comprised of clinicians and other experts from varied care settings, and also include the perspectives of patients, employers, health plans, public health agencies, and community coalitions—many of which use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. While NQF measures are used by a variety of stakeholders in the private sector, including communities, hospitals, physician groups, and health plans, legislative mandates also require that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs.

For various reasons, some previously endorsed health and well-being measures have been removed from the NQF portfolio (Appendix A). In some cases, the measure steward has discontinued maintenance of the measure, while in other cases measures lose endorsement as a result of maintenance review due to a change in evidence without an associated change in specifications, high performance on a measure signifying no further opportunity for improvement, or endorsement of a competing measure determined by the Committee to be “best in class.”

Use of Measures in the Portfolio

Many of the health and well-being measures in the portfolio are among NQF’s long-standing measures; several have been endorsed since 2006 and are in use in an array of public-sector and private-sector public reporting programs. In addition, some health and well-being measures in NQF’s portfolio are

included in the Population Health Family of Measures identified by the NQF-convened Measure Applications Partnership (MAP).[10]

Gaps in the Portfolio

The measurement gap areas identified by this Committee significantly overlap with gaps recently identified in work related to the MAP Population Health Family of Measures, in which MAP recommended areas for future measure development to the Centers for Medicare & Medicaid Services (CMS) for possible use in federal programs. These would include new measures that assess social, economic, and environmental determinants of health; physical environment (e.g., built environments); policy (e.g., smoke-free zones); specific sub-populations (e.g., people with disabilities, elderly people); patient and population outcomes linked to improvement in functional status; counseling for physical activity and nutrition in younger and middle-aged adults (18 to 65 years); and composites that assess population experience. This Health and Well-Being Committee also articulated the need for more disparities-sensitive measures, and measures that assess access to care. The Committee also highlighted the need for measures that track improvement within communities at the community level, while acknowledging the challenges of implementing performance measures with variable available data and perspectives on quality across communities.

During the measure evaluation process, the Committee struggled to apply NQF's standard measure evaluation criteria to the few submitted access-to-care measures. Generally, the link between access and quality as specified in these measures was not clearly defined. Because access to care will continue to be a focus of many health and well-being measures, the Committee recommended developing a measurement framework to help guide developers and Committee members through these issues during the measure submission and evaluation processes, respectively.

Health and Well-Being Measure Evaluation

On April 22, 2015, the Health and Well-Being Standing Committee evaluated 2 new measures and 5 measures undergoing maintenance review against NQF's standard evaluation criteria; the Committee's discussion and ratings for each measure against the criteria are summarized in Appendix A. At the outset of phase 2, 21 measures were initially identified for endorsement maintenance consideration, as noted in the following table.

Table 2. Health and Well-Being Phase 2 Summary

	Maintenance	New	Total
Measures under consideration	19	2	21
Measures rescheduled for maintenance review	6	0	6
Measures withdrawn	8	0	8
Measures recommended	4	2	6
Measure not recommended	1	0	1
Reason for not recommending	Scientific Acceptability – 1		

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the Committee's evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from March 4 through March 24, 2015, for the measures under review.

Four pre-evaluation comments were received from the Children's Hospital Association (Appendix D). These comments pertained to the 2 dental measures, measure #2689 and #2695 and the 2 measures examining developmental screening, #1448 (rescheduled for maintenance review) and #1385. In the future, the commenter encouraged NQF to consider aligning these measures with measures newly developed or under development through the Pediatric Quality Measures Program.

All submitted comments were provided to the Committee prior to its deliberations.

Overarching Issues

Measuring and Defining Access

During the Standing Committee's discussion of the measures, 1 overarching issue emerged that was factored into the Committee's ratings and recommendations for multiple measures and is not repeated in detail with each individual measure: measuring and defining access.

The Committee discussed this challenge in evaluating several of the measures that seemed to assess and reflect access to care, rather than an intended health outcome or process. Committee members expressed concern that measure #1516, #1392, #2689, and #2695 do not assess whether specific care processes are occurring during a patient encounter, but only the confirmation of a visit. For example, the 2 well-child visit measures assess only that visits occurred, not whether the child received the age-appropriate vaccinations, hearing, or vision tests. Similarly, Committee members noted that the 2 dental measures did not include the appropriate procedure codes describing which services were provided, making it difficult to establish the link between structure-process-outcome for these measures.

Both the Standing Committee and the measure developer acknowledged that the fundamental purpose of these measures is to understand access and compliance. The Dental Quality Alliance indicated that it will use the information gleaned through these initial measures to develop future process and outcome measures that will access specific care received and timeliness.

Upstream Determinants of Health

Acknowledging that this phase 2 report focuses on clinical measures, Committee members emphasized the importance of identifying and endorsing measures that address the social, environmental, and economic determinants of health. These upstream determinants of health are increasingly recognized as key to optimal health and well-being, and must be assessed, along with clinically focused measures, yet they are largely ignored in the development of quality measures and incentivized action steps.

Upstream measures are important for all populations, but are particularly salient for assessing the current state of social and economic distress that drives much of the poor mental and physical health of low to moderate income communities. Examples of such upstream measures include those related to poverty, food sources, housing, graduation rates, employment, and transportation, among others. A multistakeholder group convened by NQF has developed an *Action Guide*, which can be used as a handbook, or "how-to" manual, for population health improvement. The *Guide* suggests 10 useful steps toward building or refining initiatives to improve population health and offers ideas, examples, and links to resources that provide more detailed information. Its purpose is to support individuals and groups working together at all levels (local, state, and national) to successfully promote and improve population health over time.

Achieving the potential of population health measurement that truly reflects upstream determinants of health will require public health officials, health system leaders, and others to work together to develop suitable population health measures. These measures, while used by different groups for different purposes, will provide stakeholders with a more comprehensive picture of a community's health. As a first step, developing such sets of measures should begin with clearly defining the purpose of a set(s) of population health measures that focuses on shared accountability of the healthcare sector, public health agencies, and others for outcomes.[11]

Update to NQF Pneumococcal Vaccination Standard Specifications

The Centers for Disease Control and Prevention (CDC) estimates that each year pneumococcal disease—including pneumonia, bacteremia, and bacterial meningitis—results in approximately 40,000 deaths, mostly of Americans 65 years old or older. U.S. Public Health Service data suggest that nearly half of these deaths could be prevented through vaccination.

In response to a growing proliferation of care setting-specific influenza and pneumonia vaccination measures, often with slightly different specifications, CMS requested in 2008 that NQF recommend a standardized set of specifications for both types of immunizations. The pneumococcal vaccination specifications developed under that project were based on the then CDC Advisory Committee on Immunization Practices' (CDC/ACIP) recommended administration of PPSV23 (Pneumovax) in adults aged ≥65 years and for certain immunocompromised populations. Informed by new evidence, CDC/ACIP updated the pneumococcal vaccination guidelines, which now recommend that PCV13 (Prevnar 13) should be added to the vaccination schedule.

Three new guidelines were released for the following cohorts:

1) Immunocompromised individuals 6 to 18 years[12]
2) Immunocompromised individuals 19 to 64 years [13]
3) Adults age ≥65 years [14,15,1,]

[1] Since NQF consideration, CDC/ACIP published revised guidelines in September 2015 that recommend that the interval between the 2 vaccines be ≥1 year regardless of the order of PPSV23 and PCV13 for adults ≥65 years with no underlying medical condition.

The 5 endorsed pneumococcal vaccination measures in the NQF portfolio 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.

On March 12, 2015, NQF convened a subset of the Health and Well-Being Standing Committee "Workgroup" to discuss updates to the NQF standard specifications for pneumococcal vaccinations and present recommendations to the full Committee. The Workgroup and the Committee reviewed the following materials:

- CDC/ACIP guidelines from 2012, 2013, and 2014 to provide background on the guideline changes for 3 different cohorts (6 to 18 years, 19 to 64 years, and ≥65 years).
- Drafts of 3 sets of specifications that redlined the NQF standard specifications to align with the changes in the guidelines based on age cohort.

Each guideline addresses a different population (immunocompromised individuals 6-18 years, immunocompromised individuals 19-64 years, and individuals ≥ 65 years) and recommends administering the vaccine on slightly different schedules. Overall, the Committee agreed with the Workgroup's recommended specification changes to align the NQF specifications with the updated guidelines issued by CDC/ACIP. Specifically, the Committee concurred with the Workgroup's recommendation to establish a set of specifications for each cohort instead of compounding details into 1 set of specifications.

A summary of other key issues that arose from the Committee and/or Workgroup discussions is below. The specifications can be found in Appendix E.

Denominator Specifications

Previously, the NQF specifications for the denominator population included anyone in a nursing home or long-term care facility, regardless of age; the current guidelines include only patients with an identified high-risk condition, with no reference to specific care settings.

- The Workgroup questioned whether there is evidence of burden or benefit in excluding patients who reside in a long-term care facility. The CDC staff was not aware of any analyses that examined the impact of excluding this target population.
- The Workgroup agreed not to expand the denominator beyond the care settings specified in the revised guidelines.

Time Window

The Workgroup discussed a potential time-window issue related to the suggested 8-week interval between administration of PCV13 and PPSV23. Essentially, patients who are discharged during week 2 or beyond, during the last 8 weeks of the calendar year, will not be included for the measurement period.

- This level of detail is generally considered in implementation microspecifications, with instructions provided on how to handle these cases by the implementing entity. As with other NQF projects, NQF will not provide implementation guidance or microspecifications.

Second Vaccination Dose

The Workgroup discussed the guidelines' recommendation for a second dose (booster) of PPSV23 5 years after the first dose is administered for persons under 65 years of age. Members noted the implementation challenges and potential threats to data integrity because of the large time window. The Workgroup and Committee agreed that the primary vaccination should be the focus of the measure and not the inclusion of the booster.

- According to the CDC, the repeat PPSV23 dose for immunocompromised persons 5 years after the first if initial vaccination occurs before age 65 is not a new recommendation. The NQF Committee that developed the original standardized specifications opted not to incorporate it into the measure specifications.

Committee Recommendation

The full Standing Committee reviewed and approved the Workgroup's draft specifications and recommendations; these were available for NQF member and public comment, which took place from May 29-June 29, 2015, and NQF member Vote, July 22-August 5, 2015.

One comment supported NQF's efforts to revise 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 1 of the vaccinations is cost-prohibitive, which may penalize physicians and other clinicians who care for underserved populations. Lastly, the commenter noted that exceptions should be made for patients with limited life expectancy (e.g., exclusion of hospice patients). One commenter agreed with the decision to defer measures based on changing evidence related to pneumococcal standards.

Summary of Measure Evaluation

The following brief summaries of the measures and their evaluations highlight the major issues considered by the Committee. Details of the Committee's discussion and ratings of the criteria are included in Appendix A.

0280: Dehydration Admission Rate (PQI 10) (Agency for Healthcare Research and Quality, AHRQ)—Recommended

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. **Measure Type:** Outcome. **Level of Analysis:** Population: National, Regional, County or City. **Setting of Care:** Hospital/Acute Care Facility. **Data Source**: Administrative claims.

This measure has been NQF-endorsed since 2007 and is part of the AHRQ Prevention Quality Indicators. The measure initially was considered during Health and Well-Being phase 1, when the Committee questioned the utility of this measure given a shift toward observation stays where most dehydration cases are assessed and treated. (Some Committee members inquired whether improvements in Emergency Department (ED) management of dehydration and related billing changes decreased the prevalence of dehydration related admissions.) To address these concerns, the Committee deferred final endorsement consideration to phase 2 to allow AHRQ sufficient time to conduct the necessary analyses on these factors. The data revealed that while an increasing number of dehydration events are assessed and treated in the in ED and outpatient observation units, the majority are still assessed and treated during inpatient hospitalizations. In light of these new data, the Committee voted to recommend the measure for continued endorsement.

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5) (The Child and Adolescent Health Measurement Initiative, CAHMI)—Not Recommended

Description: The measure assesses whether the parent or caregiver completed a developmental screening tool meant to identify children at risk for developmental, behavioral, and social delays. Developmental screening is defined as a standardized tool that assesses the child's risk for developmental, behavioral, and social delays. The American Academy of Pediatrics (AAP) recommends standardized screening using an approved screening tool as the best method of identifying children at risk for developmental, behavioral and/or social delays. **Measure Type**: Process. **Level of Analysis:** Population: National, Regional, State. **Setting of Care:** Other. **Data Source**: Patient Reported Data/Survey.

This measure has been NQF-endorsed since 2011 and is part of the National Survey for Children's Health dataset. It assesses whether developmental screening occurred, as recommended, using a standardized tool. The measure is based on AAP guidelines, which recommend standard screening using an approved screening tool to identify children at risk for developmental, behavioral, and/or social delays. The Committee was concerned that the measure is based on guidelines developed from expert opinion only. Additionally, the Committee expressed concern about the lack of information in the measure submission form that demonstrated the link between developmental screening via various unspecified tools and improvements in health outcomes. With regard to the Scientific Acceptability of the Measure Properties, the measure did not pass the Reliability subcriterion because of the small sample size (n=23) used to test the measure. Issues with the validation of the (unspecified) screening tool(s) also were discussed. While the Committee acknowledged the importance of developmental screening, the link between this process measure to outcomes was not fully established. The Committee encouraged the developer to

revise the measure as suggested and to include non-English speakers in testing for a future iteration of the measure.

1392: Well-Child Visits in the First 15 Months of Life (National Committee for Quality Assurance, NCQA)—Recommended

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. **Type of Measure**: Process. **Level of Analysis:** Health Plan, Integrated Delivery System. **Setting of Care:** Ambulatory Care, Clinician Office/Clinic. **Data Source**: Administrative claims, Electronic Clinical Data, Paper Medical Records.

This measure has been NQF-endorsed since 2011. The measure is based on the AAP and Bright Future guidelines, which recommend 8 well-care visits from the time a child is born to the point at which he or she reaches 15 months of age. The measure is supported by 2 clinical practice guidelines that are based on expert opinion. While reviewing Scientific Acceptability, some Committee members expressed concern that the reliability testing only assessed children who received 6 or more visits. The Committee requested that the developer submit additional reliability testing within 1 year that includes measure score reliability for well-child visits from 0 through 5 visits. NCQA expressed a willingness to work with the Committee and NQF staff to update the reliability testing, but cautioned that 1 year might not be enough time to update the measure testing given NCQA's 3- to 4-year review cycle. Following this discussion, the Committee voted to recommend the measure for continued endorsement.

1407: Immunizations for Adolescents (National Committee for Quality Assurance, NCQA)—Recommended

Description: The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and 1 tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or 1 tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday. **Type of Measure**: Process. **Level of Analysis:** Health Plan, Integrated Delivery System. **Setting of Care:** Ambulatory Care, Clinician Office/Clinic. **Data Source**: Administrative claims, Electronic Clinical Data, Paper Medical Records.

This measure has been NQF-endorsed since 2011. It encompasses several immunizations to ensure that adolescents receive the recommended immunizations based on CDC/ACIP guidelines. The Committee noted that the measure has been in use by health plans for several years and that the evidence supporting the measure was very strong. After discussion, the Committee voted to recommend the measure for continued endorsement and recommended that the developer consider the inclusion of meningococcal and human papilloma virus (HPV) vaccines in a future iteration of the measure.

1516: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (National Committee for Quality Assurance, NCQA)—Recommended

Description: The percentage of children 3-6 years of age who had 1 or more well-child visits with a primary care provider (PCP) during the measurement year. **Type of Measure**: Process. **Level of Analysis:** Health Plan, Integrated Delivery System. **Setting of Care:** Ambulatory Care, Clinician Office/Clinic. **Data Source**: Administrative claims, Electronic Clinical Data, Paper Medical Records.

This measure has been NQF-endorsed since 2011. The measure is based on the AAP and Bright Futures guidelines, which recommend at least 4 well-child visits for children 3-6 years of age. The measure assesses access, i.e., the frequency of visits, rather than the care or services rendered during the visits. Again, the Committee noted the inherent challenges of linking the number of visits to improved health outcomes. Furthermore, Committee members questioned the evidence base for well-child visits in this age cohort (3-6 years), which was not as strong as the evidence supporting #1392 (0-15 months).

Following detailed review of the guidance for evaluating the clinical evidence, the Committee evoked the "insufficient evidence with exception" option, agreeing that it was appropriate to hold providers accountable for performance in the absence of empirical evidence for the benefit of the patient. After discussion, the Committee voted to recommend the measure for continued endorsement.

2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (American Dental Association, DQA)—Recommended

Description: Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children. **Type of Measure**: Outcome. **Level of Analysis:** Integrated Delivery System. **Setting of Care:** Emergency Medical Services/Ambulance. **Data Source**: Administrative claims.

This is a newly submitted oral health measure developed by the DQA on behalf of the American Dental Association. The measure is based on data from the Nationwide Emergency Department Sample, the largest all-payer emergency department visits database in the United States; multiple studies; and 2 guidelines.

The Committee would have preferred that the developer had presented stronger evidence that showed how prevention impacts caries-related ED visits. Some Committee members cautioned against blind comparisons of measure scores without considerations of the variability within and between health systems (e.g., ED variability in after-hours access). The DQA explained that the measure is intended to assess the severity of the unaddressed disease through any care mechanism. The Committee also questioned why the measure was specified for an integrated health delivery system versus a health plan. The developer confirmed that the measure should not be specified for health plans in recognition that not every health plan can implement the measure, since it requires data on individual visits for both ED and dental services. These data are available to Medicaid programs, but may not be available to all health plans. The developer reiterated that this measure is intended for use at the Medicaid program level. After discussion, the Committee voted to recommend the measure for endorsement and reiterated that the measure should not be used to compare performance between health systems within a community.

2695: Follow-Up after Emergency Department Visit by Children for Dental Caries American Dental Association, DQA)—Recommended

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. **Type of Measure**: Process. **Level of Analysis:** Integrated Delivery System. **Setting of Care:** Ambulatory Care, Clinician Office/Clinic, Emergency Medical Services/Ambulance. **Data Source**: Administrative claims.

This is a newly submitted oral health measure developed by the DQA on behalf of the American Dental Association. The measure examines the percentage of individuals 0 to 20 years of age who visit a dentist within 7 days and 30 days of an ED visit for dental caries-related complications. The absence of Current Dental Terminology (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 measure is to assess access to follow-up care. The developer also 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. After discussion, the Committee voted to recommend the measure for endorsement.

Measures Withdrawn By the Developer or Removed From Further Consideration for Endorsement

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

Table 3: Measures Withdrawn by the Developer or Removed From Further Consideration of Endorsement

Measure	Measure Steward	Reason for Withdrawal
0617: High Risk for Pneumococcal Disease - Pneumococcal Vaccination	ActiveHealth Management	The measure steward elected to retire the measure's endorsement.
1388: Annual Dental Visit (ADV)	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: A more focused measure of dental care for children is now included in the Child Core Set.
1396: Healthy Physical Development by 6 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure.)
1397: Sudden Infant Death Syndrome Counseling	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA is not currently using this measure in other major programs to the extent where the level of effort required to maintain endorsement is equivalent.
1399: Developmental Screening in the First Three Years of Life	National Committee for Quality Assurance	There is a similar measure of developmental screening included in the Child Core Set.
1419: Primary Caries Prevention Intervention as Part of Well/Ill Child	University of Minnesota	The measure submission was not in compliance with NQF's "conditions for consideration."

Measure	Measure Steward	Reason for Withdrawal
Care as Offered by Primary Care Medical Providers		
1512: Healthy Physical Development by 13 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure).
1514: Healthy Physical Development by 18 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure).

Endnotes

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Appendix A: Details of Measure Evaluation

Measures Recommended

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

0280: Dehydration Admission Rate (PQI 10)—Recommended

Submission | Specifications

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**

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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.

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2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criterion.</u>

****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**

<u>Rationale</u>:

- 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 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.

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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)

<u>Rationale</u>:

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

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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 EDs 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).

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5. Related and Competing Measures

- No related or competing measures noted.

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

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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 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 provide insight on burden of illness. PQI 10 is 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 this 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 PQI 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.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-13; N-0; A-0

Decision: Approved for continued endorsement

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8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for continued endorsement

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9. Appeals

No appeals were received for this measure.

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

Submission | Specifications

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 Futures, 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 10^{th} and 90^{th} 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**

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 advised it is willing to update the reliability testing, but given NQCA's three to 4 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.

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-13; N-0; A-0

Decision: Approved for continued endorsement

8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for continued endorsement

9. Appeals

No appeals were received for this measure.

1407: Immunizations for Adolescents—Recommended

Submission | Specifications

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.
- 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).

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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 American Academy of Family Physicians 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.

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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.

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-13; N-0; A-0

Decision: Approved for continued endorsement

8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for continued endorsement

9. Appeals

No appeals were received for this measure.

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

Submission | Specifications

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-child care visits for children 3-6 years of age.
- The Committee acknowledged that well-child 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.

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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-8**; **L-0**; **I-2** 2b. Validity: **H-8**; **M-9**; **L-3**; **I-0**

Rationale:

- Committee members asked for 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.

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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.

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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.

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5. Related and Competing Measures

- No related or competing measures noted.

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

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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 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.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-13; N-0; A-0

Decision: Approved for continued endorsement

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8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for continued endorsement

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9. Appeals

No appeals were received for this measure.

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

Submission | Specifications

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

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

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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: <u>The measure meets the Scientific Acceptability criterion.</u>

(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**

<u>Rationale</u>:

- 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 provider utilization numbers, the developer 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)

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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 out the underlying assumption that ED visits for dental caries implies unaddressed disease and requested that the developer specifically define how it intends 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 measure 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-13; N-0; A-0

Decision: Approved for endorsement

8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for endorsement

9. Appeals

No appeals were received for this measure.

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

Submission | Specifications

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

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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: <u>The measure meets the Scientific Acceptability criterion.</u>

(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**

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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 also noted the difficulty of implementation 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:

- 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-13; N-0; A-0

Decision: Approved for endorsement

8. Board of Directors Vote: Yes (September 2, 2015)

Decision: Ratified for endorsement

9. Appeals

No appeals were received for this measure.

Measure Not Recommended

1385: Developmental screening using a parent completed screening tool (Parent report, Children 0-5)—Not Recommended

Submission

Description: The measure assesses whether the parent or caregiver completed a developmental screening tool meant to identify children at-risk for developmental, behavioral and social delays. Developmental screening is defined as a standardized tool that assesses the child's risk for developmental, behavioral and social delays. The American Academy of Pediatrics recommends standardized screening using an approved screening tool as the best method of identifying children at risk for developmental, behavioral and/or social delays.

The items assessing developmental screening in the National Survey of Children´s Health are meant to assess whether the parent or caregiver completed a standardized developmental screening tool. The items are age-specific and anchored to parent-completed tools (a majority of health care providers implementing the Bright Futures recommendations for standardized screening for all children utilize parent-completed tools due to their validity and feasibility). The age-specific items assess whether children 10-71 months are screened.

Numerator Statement: Percentage of children whose parents completed a standardized developmental screening tool to identify children at risk for developmental, behavioral, and social delays at a health care visit during the previous 12 months

Denominator Statement: Children age 10 months - 5 years (71 months) with a health care visit in the past 12 months (see 2a.8 below for further definition of "health care visit")

Exclusions: Child excluded from denominator if age is less than 10 months or more than 5 years and did not have at least one health care visit in the past 12 months

Adjustment/Stratification:

Level of Analysis: Population : National, Population : Regional, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Patient Reported Data/Survey

Measure Steward: The Child and Adolescent Health Measurement Initiative

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STANDING COMMITTEE MEETING 04/22/2015

1. Importance to Measure and Report: Consensus was not reached on the Importance criterion.

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)

1a. Evidence: **H-2**; **M-7**; **L-5**; **I-5; IE-2**; 1b. Performance Gap: **H-7**; **M-9**; **L-2**; **I-3**

Rationale:

- Committee members agreed that while developmental screening is important to assess, the measure specifies use of a parent-reported screening tool, without identifying specific validated screening tool(s) to be used during the patient encounter.

- Committee members noted that the measure is based on the AAP and Bright Futures guidelines, which are derived from expert opinion only.
- The Committee noted that there are no validated methods to demonstrate that developmental screening via a standardized questionnaire leads to improvements in health outcomes.
- The Committee recognized the large performance gap; only 30 percent of children are screened for developmental problems using standardized questionnaires. The developer also conveyed that this measure has promoted increased screening and is particularly important to informing policy decisions, particularly for Title V entities that receive block grants to ensure a focus on family-centered care, evidence-based practices, and quality improvement.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the reliability subcriterion.</u>

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

2a. Reliability: **H-1**; **M-5**; **L-8**; **I-7**

<u>Rationale</u>:

- Committee members were very concerned that the measure is based on a parent-reported developmental screening survey that has not been validated. Committee members mentioned several validated screening tools such as the Pediatric Evaluation of Developmental Status (PEDS) and Ages and Stages questionnaire (ASQ) and asked the developer why the measure did not identify use of these or other validated screening tools.
- Committee members also expressed concern about potential recall bias. The developer confirmed that this issue was considered during development of the screening tool; however, those data were not included in the measure submission.
- Committee members asked why dental visits were included in the denominator population. The developer noted that the denominator is aligned with the National Survey of Children's Health, which is defined as one or more preventive health care visits, and/or one or more preventive dental care visits and/or a visit with a mental health professional and/or a visit with a specialist. The developer noted that the denominator can include any of these qualifying visits.
- Committee members were concerned about the small sample size used to conduct reliability testing for this parent-reported survey (n=23).
- Committee members also questioned the consistent administration and documentation of the survey across settings.

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

Comments received:

- This measure received a set of two similar comments that noted while screening can be beneficial and easily implemented, a reliable and valid tool must be used and the tool should be specified in the indicator—the position taken by the Committee. One of these comments further agreed with the Committee's recommendation not to endorse this measure based on the lack of specificity to use validated screening tools.

Measures Rescheduled for Maintenance Review

Maintenance review for the following measures was rescheduled for future consideration:

Measure	Reason for deferral
0043: Pneumococcal Vaccination Status for Older Adults (PNU)	The CDC guidelines have been updated for pneumococcal vaccinations. After internal discussions with the measure developers, CMS, and NQF leadership, NQF decided to reschedule maintenance review of the five pneumococcal vaccination measures until a subsequent phase of Health and Well-Being. In the interim, the Health and Well-Being Standing Committee endorsed updated NQF Standard Specifications for Pneumococcal Vaccinations.
0525: Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health)	
0682: Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	
0683: Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)	
1653: Pneumococcal Immunization	
1448: Developmental Screening in the First Three Years of Life	Measure 1448 is a time-limited measure. As a requirement of this designation, the developer is expected to submit testing on the measure at the time of endorsement reconsideration. Due to scheduling conflicts and personnel changes, NQF and the measure developed agreed to reschedule maintenance review measure until a subsequent phase when additional testing analysis can be provided.

Measures Withdrawn from Consideration

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

Measure	Measure Steward	Reason for Withdrawal
0617: High Risk for Pneumococcal Disease - Pneumococcal Vaccination	ActiveHealth Management	The measure steward elected to retire the measure's endorsement.
1388 : Annual Dental Visit (ADV)	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: A more focused measure of dental care for children is now included in the Child Core Set.
1396 : Healthy Physical Development by 6 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure).

Measure	Measure Steward	Reason for Withdrawal
1397 : Sudden Infant Death Syndrome Counseling	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA is not currently using this measure in other major programs to the extent where the level of effort required to maintain endorsement is equivalent.
1399 : Developmental Screening in the First Three Years of Life	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: There is a similar measure of developmental screening included in the Child Core Set.
1419 : Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers	University of Minnesota	The measure submission was not in compliance with NQF's "conditions for consideration."
1512 : Healthy Physical Development by 13 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure).because of poor uptake in the use of the measure.
1514 : Healthy Physical Development by 18 Years of Age	National Committee for Quality Assurance	The measure steward elected to retire the measure's endorsement: NCQA's measure (NQF #0024) *Weight assessment and counseling for nutrition and physical activity for children/adolescents* is already endorsed for children ages 3-17. (This is a duplicative measure).

Appendix B: Pneumococcal Vaccination Draft Standard Specifications

	NQF Standard Specifications, Immunocompromised Individuals 6 to 18 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine ≥ eight weeks after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ eight weeks after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 ≥ eight weeks following administration of PCV13 OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 ≥ eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year)
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the measurement year) • age 6-18 years with prevalent high-risk conditions of cerebrospinal fluid leak, cochlear implant, sickle cell disease/other hemaglobinopathy, asplenia, congenital or acquired immunodeficiency, HIV infection, ESRD, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression, solid organ transplant, multiple myeloma *See* MMWR *62(25) June 28, 2013.*
Denominator Exclusions	Hospital patients who died before discharge

	NQF Standard Specifications, Immunocompromised Adults ≥19 to 64 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine ≥ 1 year after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ 1 year after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 at least eight weeks following administration of PCV13 OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 at least eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year)
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the measurement year) • age ≥19-64 years with prevalent high-risk conditions of cerebrospinal fluid leak, cochlear implant, sickle cell disease/other hemaglobinopathy, asplenia, congenital or acquired immunodeficiency, HIV infection, ESRD, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression, solid organ transplant, multiple myeloma *See* MMWR *61(40) October 12, 2012.*
Denominator Exclusions	Hospital patients who died before discharge

	NQF Standard Specifications, Adults ≥ 65 years
Numerator	Number of persons specified in the denominator who, • ever received the PPSV23 (pneumococcal polysaccharide) vaccine and received the PCV13 vaccine ≥1 year after receipt of PPSV23 • have documented administration of PPSV23 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider and documented administration of PCV13 by the provider or patient (or responsible party/legal guardian) reported receipt from another provider ≥ 1 year after receipt of PPSV23 OR • received pneumococcal vaccine of PCV13 first, followed by PPSV23 at least eight weeks following administration of PCV13[1] OR • have documented administration of PCV13 first by the provider or patient (or responsible party/legal guardian) reported receipt from another provider, followed by documented administration of PPSV23 at least eight weeks following administration of PCV13 by the provider or patient (or responsible party/legal guardian reported receipt from another provider OR • were assessed and offered but declined the vaccination (computed and reported separately) OR • were assessed and determined to have medical contraindication(s) (computed and reported separately) of anaphylactic hypersensitivity to component(s) of the vaccine, or bone marrow transplant within past 12 months (<12 months prior to encounters during the measurement year), or receiving course of chemotherapy or radiation therapy (<2 weeks prior to encounters during the measurement year).
Denominator	Number of persons, • in a facility, agency, or practice with an encounter (or in a defined population) during the measurement year (OR for health plan measures, enrolled with a plan during the measurement year) • who is age 65 or older
Denominator Exclusions	Hospital patients who died before discharge

[1] Since NQF consideration, CDC/ACIP published revised guidelines in September 2015 that recommend that the interval between the two vaccines be ≥1 year regardless of the order of PPSV23 and PCV13 for adults ≥65 years with no underlying medical condition.

Appendix C: NQF Health and Well-Being Portfolio and Related Measures [1]

Health-Related Behaviors and Practices to Promote Healthy Living

Measure Number	Measure Title
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
0029	Physical Activity in Older Adults (PAO)
1348	Children Age 6-17 Years who Engage in Weekly Physical Activity
1349	Child Overweight or Obesity Status Based on Parental Report of Body-Mass-Index (BMI)

Community-Level Indicators of Health and Disease

Measure Number	Measure Title
0272	Diabetes, short-term complications (PQI 1)
0274	Diabetes, long-term complications (PQI 3)
0277	Congestive Heart Failure Admission Rate (PQI 8)
0280	Dehydration Admission Rate (PQI 10)
0281	Urinary infections (PQI 12)
0285	Lower extremity amputations among patients with diabetes (PQI 16)
0638	Uncontrolled Diabetes Admission Rate (PQI 14)
0724	Measure of Medical Home for Children and Adolescents
0727	Gastroenteritis Admission Rate (pediatric)
0728	Asthma Admission Rate (pediatric)
1999	Late HIV diagnosis
2020	Adult Current Smoking Prevalence

Modifiable Social, Economic, and Environmental Determinants of Health

Measure Number	Measure Title
0717	Number of School Days Children Miss Due to Illness
0718	Children Who Had Problems Obtaining Referrals When Needed
0719	Children Who Receive Effective Care Coordination of Healthcare Services When Needed
0720	Children Who Live in Communities Perceived as Safe
0721	Children Who Attend Schools Perceived as Safe
0723	Children Who Have Inadequate Insurance Coverage For Optimal Health
1330	Children With a Usual Source for Care When Sick
1332	Children Who Receive Preventive Medical Visits
1333	Children Who Receive Family-Centered Care
1337	Children With Inconsistent Health Insurance Coverage in the Past 12 Months
1340	Children with Special Health Care Needs (CSHCN) who Receive Services Needed for

Measure Number	Measure Title
	Transition to Adult Health Care
1346	Children Who Are Exposed To Secondhand Smoke Inside Home
1392	Well-Child Visits in the First 15 Months of Life
1516	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Primary Prevention and/or Screening

Measure Number	Measure Title
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
0038	Childhood Immunization Status
0039	Flu Shots for Adults Ages 50 and Over
0041	Influenza Immunization
0043	Pneumonia vaccination status for older adults
0226	Influenza Immunization in the ESRD Population (Facility Level)
0227	Influenza Immunization
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
0431	Influenza Vaccination Coverage Among Healthcare Personnel
0522	Influenza Immunization Received for Current Flu Season
0525	Pneumococcal Polysaccharide Vaccine (PPV) Ever Received
0629	Male Smokers or Family History of Abdominal Aortic Aneurysm (AAA) - Consider Screening for AAA
0680	Percent of Nursing Home Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)
0682	Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)
0683	Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long-Stay)
1407	Immunizations by 13 years of age
1448	Developmental Screening in the First Three Years of Life
1653	Pneumococcal Immunization (PPV 23)
1659	Influenza Immunization
1959	Human Papillomavirus Vaccine for Female Adolescents
2372	Breast Cancer Screening

Oral Health

Measure Number	Measure Title
1334	Children Who Received Preventive Dental Care
1335	Children Who Have Dental Decay or Cavities
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
2511	Utilization of Services, Dental Services
2517	Oral Evaluation, Dental Services
2528	Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services

[1] NQF has assigned some measures related to health and well-being to other projects, primarily to manage the size of the portfolio and take advantage of technical expertise. For example, the endocrine project reviewed measures that assess osteoporosis screening, and the infectious disease project reviewed measures for HIV/AIDS screening.

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Comments Received Prior to Committee Evaluation

Comments received March 4 - March 24, 2015

Topic	Commenter	Comment
2689 Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Submitted by Children's Hospital Association	The level of analysis for this measure is stated as "integrated delivery system;" however, it appears that this measure was tested at the state level. Can the measure developer address the application of the measure to a smaller population? The Children's Hospital Association encourages the National Quality Forum to consider how these measures might be complemented with measures newly developed or under development through the Pediatric Quality Measures Program (PQMP) in the future. For example, it is our understanding that there is a new measure available on the linkage between dental prevention and dental treatment and measures under development that address oral health and availability of services. We believe that the PQMP is a critically important vehicle for advancing children's health care quality measurement and hope to see opportunities for national vetting and endorsement of measures emerging from this program.
2689: Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	Submitted by Children's Hospital Association	The level of analysis for this measure is stated as "integrated delivery system;" however, it appears that this measure was tested at the state level. Can the measure developer address the application of the measure to a smaller population? The Children's Hospital Association encourages the National Quality Forum to consider how these measures might be complemented with measures newly developed or under development through the Pediatric Quality Measures Program (PQMP) in the future. For example, it is our understanding that there is a new measure available on the linkage between dental prevention and dental treatment and measures under development that address oral health and availability of services. We believe that the PQMP is a critically important vehicle for advancing children's health care quality measurement and hope to see opportunities for national vetting and endorsement of measures emerging from this program.

Topic	Commenter	Comment
1385: Developmental screening using a parent completed screening toll (Parent report, Children 0-5)	Submitted by Children's Hospital Association	The Children's Hospital Association encourages the National Quality Forum to consider how these measures might be complemented with measures newly developed or under development through the Pediatric Quality Measures Program (PQMP) in the future. For example, it is our understanding that there are two new measures related to follow-up after developmental screening that are currently available and additional measures (follow up referral tracking) under development. We believe that the PQMP is a critically important vehicle for advancing children's health care quality measurement and hope to see opportunities for national vetting and endorsement of measures emerging from this program.
1448: Developmental Screening in the First Three Years of Life	Submitted by Children's Hospital Association	The Children's Hospital Association encourages the National Quality Forum to consider how these measures might be complemented with measures newly developed or under development through the Pediatric Quality Measures Program (PQMP) in the future. For example, it is our understanding that there are two new measures related to follow-up after developmental screening that are currently available and additional measures (follow up referral tracking) under development. We believe that the PQMP is a critically important vehicle for advancing children's health care quality measurement and hope to see opportunities for national vetting and endorsement of measures emerging from this program.

Appendix F: Measure Specifications

0280 Dehydration Admission Rate (PQI 10)

STATUS

Standing Committee Review

STEWARD

Agency for Healthcare Research and Quality

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.

TYPE

Outcome

DATA SOURCE

Administrative claims All analyses were completed using data from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2007-2012. HCUP is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ).1 HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of encounter-level health care data. The HCUP SID contain the universe of the inpatient discharge abstracts in participating States, translated into a uniform format to facilitate multi-State comparisons and analyses. All states provide data for community hospitals and together, the SID encompass about 97 percent of all U.S. community hospital discharges (in 2012, 46 states participated for a total of about 34 million hospital discharges from community hospitals). As defined by the American Hospital Association, community hospitals are all non-Federal, short-term, general or other specialty hospitals, excluding hospital units of institutions. Included among community hospitals are specialty hospitals such as obstetrics–gynecology, ear–nose–throat, orthopedic, pediatric institutions, short-stay rehabilitation, and long-term acute care. Also included are public hospitals and academic medical centers. In the 2012 HCUP SID databases, 97.4% of all discharges are from community hospitals. Some states also include additional hospital types, which make up the remaining 2.6% of discharges, specifically psychiatric facility, alcohol and drug dependency facilities, and military hospitals.

The SID data elements include ICD-9-CM coded principal and secondary diagnoses and procedures, additional detailed clinical and service information based on revenue codes, admission and discharge status, patient demographics, expected payment source (Medicare, Medicaid, private insurance as well as the uninsured), total charges and length of stay (www.hcup-us.ahrq.gov).

The area universe is defined as the county of the residence of the patient for discharges in the hospital universe. The hospital universe is defined as all hospitals located in the U.S. that are

open during any part of the calendar year and included in the SID database (see description above).

As noted, 97.4% of discharges in the 2012 SID are from “community hospitals.” The AHA defines community hospitals as follows: "All non-Federal, short-term, general, and other specialty hospitals, excluding hospital units of institutions." Starting in 2005, the AHA included long-term acute care facilities in the definition of community hospitals. These facilities provide acute care services to patients who need long-term hospitalization (stays of more than 25 days, but with an average stay of less than 30 days).

For the purpose of these analyses visits made by individuals residing in states that are not included in the HCUP databases for excluded from numerator counts.

Population estimates are derived from the US Census and are detailed in the 2013 Population File for use with the AHRQ Quality Indicators posted on the AHRQ QI website: http://www.qualityindicators.ahrq.gov/Downloads/Software/SAS/V45/AHRQ%20QI%20Population%20File%20V4.5.pdf and provided in the supplemental materials. Public-use files of intercensal and postcensal estimates of county-level population by five-year age group, sex, race, and Hispanic origin were acquired from the Census Bureau (http://www.census.gov/popest/) covering the years 1995 through 2011.

Available at measure-specific web page URL identified in S.1 Attachment Dehydration_Admission_Rate_PQI_10.xlsx

LEVEL

Population : County or City, Population : National, Population : Regional, Population : State

SETTING

Hospital/Acute Care Facility

TIME WINDOW

Users may specify a time period; but the time period is generally one year. Note that the reference population rates and signal variance parameters assume a one-year time period.

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 (available at http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx) and in the supporting information.

NUMERATOR DETAILS

ICD-9-CM Dehydration diagnosis codes:

2765 HYPOVOLEMIA (not active in FY 2013)

27650 VOLUME DEPLETION NOS

27651 DEHYDRATION

27652 HYPOVOLEMIA

ICD-9-CM Hyperosmolality and/or hypernatremia diagnosis codes:

2760 HYPEROSMOLALITY

ICD-9-CM Gastroenteritis diagnosis codes:

00861 INTES INFEC ROTAVIRUS

00862 INTES INFEC ADENOVIRUS

00863 INT INF NORWALK VIRUS

00864 INT INF OTH SML RND VRUS

00865 ENTERITIS D/T CALICIVIRS

00866 INTES INFEC ASTROVIRUS

00867 INT INF ENTEROVIRUS NEC

00869 OTHER VIRAL INTES INFEC

0088 VIRAL ENTERITIS NOS

0090 INFECTIOUS ENTERITIS NOS

0091 ENTERITIS OF INFECT ORIG

0092 INFECTIOUS DIARRHEA NOS

0093 DIARRHEA OF INFECT ORIG

5589 NONINF GASTROENTERIT NEC

ICD-9-CM Acute kidney injury diagnosis codes:

5845 AC KIDNY FAIL, TUBR NECR

5846 AC KIDNY FAIL, CORT NECR

5847 AC KIDNY FAIL, MEDU NECR

5848 ACUTE KIDNEY FAILURE NEC

5849 ACUTE KIDNEY FAILURE, NOS

586 RENAL FAILURE NOS

9975 SURG COMPL-URINARY TRACT

The PQI reference population includes discharges with MDC 14 and age less than 18 years; however, the DRG and MS-DRG grouper logic precludes assignment of MDC 14 for discharge records with a PQI defining principal diagnosis.

Exclude cases:

- transfer from a hospital (different facility)
- transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- transfer from another health care facility
- with any-listed ICD-9-CM diagnosis codes for chronic renal failure
- with missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing)

Rationale for exclusions: PQIs, and the Ambulatory Care Sensitive Conditions (ACSCs) and Avoidable Hospital Conditions (AHCs) upon which they were based, have always focused on the non-institutionalized, community-dwelling population. Including transfers from other acute care hospitals would clearly be inappropriate, because that would lead to double-counting the same

inpatient episode if the patient's condition required transfer from one hospital to another. Including transfers from long-term care facilities could be considered, but PQIs re-specified in this way would require re-validation. Conceptually, these measures were designed to assess population-level access to timely, high-quality outpatient services, for the purpose of managing a chronic disease, preventing complications of a chronic disease, or diagnosing acute illnesses before they progress to require inpatient treatment. Residents of skilled nursing facilities do not lack for access to care, because they are surrounded by care providers. If their hospitalization rates are high (after risk-adjustment), it is presumably due to problems in care coordination or care within those specific facilities, not problems in ambulatory care.

See Prevention Quality Indicators Appendices: Appendix A – Admission Codes for Transfers

ICD-9-CM Chronic renal failure diagnosis codes1:

40300 MAL HY KID W CR KID I-IV

40301 MAL HYP KID W CR KID V

40310 BEN HY KID W CR KID I-IV

40311 BEN HYP KID W CR KID V

40390 HY KID NOS W CR KID I-IV

40391 HYP KID NOS W CR KID V

40400 MAL HY HT/KD I-IV W/O HF

40401 MAL HYP HT/KD I-IV W HF

40402 MAL HY HT/KD ST V W/O HF

40403 MAL HYP HT/KD STG V W HF

40410 BEN HY HT/KD I-IV W/O HF

40411 BEN HYP HT/KD I-IV W HF

40412 BEN HY HT/KD ST V W/O HF

40413 BEN HYP HT/KD STG V W HF

40490 HY HT/KD NOS I-IV W/O HF

40491 HYP HT/KD NOS I-IV W HF

40492 HY HT/KD NOS ST V W/O HF

40493 HYP HT/KD NOS ST V W HF

585 CHRONIC RENAL FAILURE (not active in FY 2013)

5855 CHRON KIDNEY DIS STAGE V

5856 END STAGE RENAL DISEASE

See Prevention Quality Indicators technical specifications and appendices for additional details (available at http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx) 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.

DENOMINATOR DETAILS

The term “metropolitan area” (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, “area” could refer to either 1) FIPS county, 2) modified FIPS county, 3) 1999 OMB Metropolitan Statistical Area, or 4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the QI software. See AHRQ QI website or supplemental information for 2013 Population File Denominator report for calculation of population estimates embedded within AHRQ QI software programs.
http://www.qualityindicators.ahrq.gov/Downloads/Software/SAS/V45/AHRQ%20QI%20Population%20File%20V4.5.pdf

EXCLUSIONS

Not applicable

EXCLUSION DETAILS

Not applicable

RISK ADJUSTMENT

Statistical risk model

The predicted value for each case is computed using a hierarchical model (logistic regression with area random effect) and covariates for gender and age (in 5-year age groups. Because we cannot individually observe the age and gender of each person in a counties population, we use the age and gender distribution of the county to estimate the number of “cases” in each age*gender group. The reference population used in the regression is the universe of discharges for states that participate in the HCUP State Inpatient Data (SID) for the year 2010 (combined), a database consisting of 46 states and approximately 38 million adult discharges, and the U.S. Census data by county. The expected rate is computed as the sum of the predicted value for each case divided by the number of cases for the unit of analysis of interest (i.e., area). The risk adjusted rate is computed using indirect standardization as the observed rate divided by the expected rate, multiplied by the reference population rate.

Additional information on methodology can be found in the Empirical Methods document on the AHRQ Quality Indicator website (www.qualityindicators.ahrq.gov) and in the supplemental information.

The specific covariates for this measure are as follow:

SEX Female

18 - 24 Males

25 - 29 Males

30 - 34 Males

35 - 39 Males

40 - 44 Males

45 - 49 Males

50 - 54 Males

55 - 59 Males

60 - 64 Males

65 - 69 Males

70 - 74 Males

75 - 79 Males

80 - 84 Males

18 - 24 Females

25 - 29 Females

30 - 34 Females

35 - 39 Females

40 - 44 Females

45 - 49 Females

50 - 54 Females

55 - 59 Females

60 - 64 Females

65 - 69 Females

70 - 74 Females

75 - 79 Females

80 - 84 Females

The risk adjustment coefficient table can be found in the supplemental materials and at the following link:

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/Parameter_Estimates_PQI_45.pdf

Available in attached Excel or csv file at S.2b

STRATIFICATION

Not applicable

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

The observed rate is the number of discharges flagged with the outcome of interest divided by the number of persons in the population at risk. The predicted rate is estimated for each person based on a logistic regression model. The expected rate is the average predicted rate for the unit of interest (i.e. the county of residence). The risk-adjusted rate is calculated using the indirect method as observed rate divided by expected rate multiplied by the reference population rate. The performance score is a weighted average of the risk-adjusted rate and the reference population rate, where the weight is the signal-to-noise ratio.

For additional information, please see supporting information in the Quality Indicator Empirical Methods. Information is also available on the AHRQ Quality Indicator website: www.qualityindicators.ahrq.gov No diagram provided

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: Not applicable

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

STATUS

Standing Committee Review

STEWARD

National Committee for Quality Assurance

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.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 1392_W15_Value_Sets_Final.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

The measurement year (12 months)

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

NUMERATOR DETAILS

This measure is specified as a hybrid measure (administrative plus medical record review) for health plans.

Administrative Specification

Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits, on different dates of service, with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

See attached code value sets.

Hybrid Specification

Seven separate numerators are calculated, corresponding to the number of members who had 0, 1, 2, 3, 4, 5, 6 or more complete well-child visits, on different dates of service, with a PCP during their first 15 months of life.

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

DENOMINATOR STATEMENT

Children 15 months old during the measurement year.

DENOMINATOR DETAILS

Product lines: Commercial, Medicaid

Ages: Children 15 months old during the measurement year.

Continuous Enrollment: 31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2013, turns 15 months old on April 9, 2014.

Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: Day the child turns 15 months old.

Benefit: Medical.

Event/diagnosis: None.

EXCLUSIONS

None

EXCLUSION DETAILS

NA

RISK ADJUSTMENT

No risk adjustment or risk stratification

NA

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Refer to items S.9 for additional denominator details and attached code value sets for codes.

Step 1. Determine the eligible population. To do so, identify children 15 months of age by the anchor date who meet the continuous enrollment and benefit requirements (S.9).

Step 2. Search administrative systems or medical records to identify numerator events for all members in the eligible population (S.6).

Step 3. Calculate the rate. No diagram provided

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5.1 Identified measures: 1332 : Children Who Receive Preventive Medical Visits

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF # 1332 specifies a denominator of “children age 0-17 years”, while our measure specifies a denominator of children 15 months or less in age. Our numerator measures whether one or more well-child visits with a PCP occurred in the past 12 months. NQF#1332 numerator assesses whether children had one or more preventive medical visits in the past 12 months. NQF #1332 is specified and tested at the population (national, region, state) level. NCQA’s measure is specified at the health plan level of accountability.

5b.1 If competing, why superior or rationale for additive value: N/A

1407 Immunizations for Adolescents

STATUS

Standing Committee Review

STEWARD

National Committee for Quality Assurance

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.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Paper Medical Records Refer to items S.9 for additional denominator details and attached code value sets for codes.

Step 1. Determine the eligible population. To do so, identify adolescents 13 years of age by the anchor date who meet the continuous enrollment and benefit requirements (S.9).

Step 2. Search administrative systems or medical records to identify numerator events for all members in the eligible population (S.6).

Step 3. For members for whom administrative data do not show a positive numerator event, search administrative data or medical records for an exclusion to immunize (S.10).

Step 4. Exclude from the eligible population members from step 3 for whom administrative system data or medical review data identified an exclusion to immunize.

Step 5. Calculate the rate.

No data collection instrument provided Attachment 1407_IMA_Value_Sets_Final.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

The measurement year (12 months)

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.

NUMERATOR DETAILS

This measure is specified as a hybrid measure (administrative plus medical record review) for health plans.

Administrative Specification

For meningococcal and Tdap or Td, count only evidence of the antigen or combination vaccine.

Meningococcal: At least one meningococcal conjugate or meningococcal polysaccharide vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the member's 11th and 13th birthdays.

Tdap/Td: Any of the following with a date of service on or between the member's 10th and 13th birthdays meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set).
- At least one tetanus, diphtheria toxoids (Td) vaccine (Td Vaccine Administered Value Set).
- At least one tetanus vaccine (Tetanus Vaccine Administered Value Set) and at least one diphtheria vaccine (Diphtheria Vaccine Administered Value Set) on the same date of service or on different dates of service.

Combination 1 (Meningococcal, Tdap/Td): Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td).

See attached code value sets.

Hybrid Specification

For meningococcal and Tdap or Td, count only evidence of the antigen or combination vaccine.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

• A note indicating the name of the specific antigen and the date of the immunization.

• A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

DENOMINATOR STATEMENT

Adolescents who turn 13 years of age during the measurement year.

DENOMINATOR DETAILS

Administrative Specification

Product lines: Commercial, Medicaid

Ages: Adolescents who turn 13 years of age during the measurement year.

Continuous Enrollment: 12 months prior to the member's 13th birthday.

Allowable gap: No more than one gap of enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date: Enrolled on the member's 13th birthday.

Benefit: Medical.

Event/diagnosis: None.

Hybrid Specification

A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate for the lowest rate or the prior year's audited, product line-specific results for the lowest rate. For information on reducing the sample size, refer to the Guidelines for Calculations and Sampling.

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.

EXCLUSION DETAILS

See attached code value sets.

RISK ADJUSTMENT

No risk adjustment or risk stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Refer to items S.9 for additional denominator details and attached code value sets for codes.

Step 1. Determine the eligible population. To do so, identify adolescents 13 years of age by the anchor date who meet the continuous enrollment and benefit requirements (S.9).

Step 2. Search administrative systems or medical records to identify numerator events for all members in the eligible population (S.6).

Step 3. For members for whom administrative data do not show a positive numerator event, search administrative data or medical records for an exclusion to immunize (S.10).

Step 4. Exclude from the eligible population members from step 3 for whom administrative system data or medical review data identified an exclusion to immunize.

Step 5. Calculate the rate. No diagram provided

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

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

STATUS

Standing Committee Review

STEWARD

National Committee for Quality Assurance

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.

TYPE

Process

DATA SOURCE

Administrative claims, Electronic Clinical Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 1516_W34_Value_Sets_Final.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic

TIME WINDOW

12 months

NUMERATOR STATEMENT

Children who received at least one well-child visit with a PCP during the measurement year.

NUMERATOR DETAILS

This measure is specified as a hybrid measure (administrative plus medical record review) for health plans.

Administrative Specification

At least one well-child visit with a PCP during the measurement years.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

See attached code value sets.

Hybrid Specification

At least one well-child visit with a PCP during the measurement years. The PCP does not have to be the practitioner assigned to the child.

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

DENOMINATOR STATEMENT

Children 3-6 years of age during the measurement year.

DENOMINATOR DETAILS

Product lines: Commercial, Medicaid

Ages: Children 3-6 years old as of December 31 of the measurement year.

Continuous Enrollment: The measurement year.

Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: December 31 of the measurement year.

Benefit: Medical.

Event/diagnosis: None.

EXCLUSIONS

None

EXCLUSION DETAILS

NA

RISK ADJUSTMENT

No risk adjustment or risk stratification

NA

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Product lines: Commercial, Medicaid

Ages: Children 3-6 years old as of December 31 of the measurement year.

Continuous Enrollment: The measurement year.

Allowable gap: No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: December 31 of the measurement year.

Benefit: Medical.

Event/diagnosis: None. No diagram provided

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5.1 Identified measures: 1332 : Children Who Receive Preventive Medical Visits

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF # 1332 specifies a denominator of “children age 0-17 years”, while our measure specifies a denominator of children 3-6 years of age. Our numerator measures whether one or more well-child visits with a PCP occurred in the past 12 months. NQF#1332 numerator assesses whether children had one or more preventive medical visits in the past 12 months. NQF #1332 is specified and tested at the population (national, region, state) level. Our measure is specified and tested at the health plan level of accountability.

5b.1 If competing, why superior or rationale for additive value: N/A

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

STATUS

Standing Committee Review

STEWARD

American Dental Association in behalf of the Dental Quality Alliance

DESCRIPTION

Number of emergency department visits for caries-related reasons per 100,000 member months for all enrolled children

TYPE

Outcome

DATA SOURCE

Administrative claims Not applicable

No data collection instrument provided Attachment Copy_of_ICD-9_code_conversions-635569309951251695.xlsx

LEVEL

Integrated Delivery System

SETTING

Emergency Medical Services/Ambulance

TIME WINDOW

12 months for both denominator and numerator

NUMERATOR STATEMENT

Number of ED visits with caries-related diagnosis code among all enrolled children

NUMERATOR DETAILS

Please see section S18.

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)

DENOMINATOR DETAILS

Please see section S18.

EXCLUSIONS

The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits.

EXCLUSION DETAILS

There are no other exclusions than those described above.

RISK ADJUSTMENT

Stratification by risk category/subgroup

Not applicable – no risk adjustment for this measure.

STRATIFICATION

There are two stratifications:

1. Age Stratification.

This measure will be stratified by age using the following categories:

<1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

No new data are needed for this stratification. Please see attached specifications for complete measure details.

These stratification categories are consistent with other recently NQF-endorsed dental measures (NQF#2511; NQF#2517). Collapsed categories were considered; however, expert consensus concluded that given the different patterns between programs, a more refined approach would be more informative to measure implementers.

2. ED Disposition Stratification.

This measure will be stratified by ED disposition using the following categories: discharged from ED and inpatient admission. Please see attached specifications for complete measure details.

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children calculation:

1. Run records for one reporting year for paid claims

2. Calculate total eligible member months as the sum of all member months for enrollees age 0 through 20 years (<21 years) as of the 15th or 30th day of the month as appropriate for when eligibility determinations are made. Either the 15th or the 30th should be selected and used consistently across all member months during the reporting period.

Reporting note for age stratifications:

- Member months will be attributed to each age stratum based on the member's age as of the 15th or 30th day of the month. Either the 15th or the 30th should be selected and used consistently across all member months during the reporting period.
- One member can contribute member months to more than one age stratum.

YOU NOW HAVE DENOMINATOR (DEN) COUNT: Total member months

3. Identify all emergency department visits for caries-related reasons occurring during eligible member months:

a. Identify a health care encounter as an ED visit if any of the following are met:

i. CPT codes 99281-99285 (ED visit for patient evaluation/management); OR

ii. Revenue code 0450-0459 (Emergency Room) or 0981 (professional fees for ER services); OR

iii. CMS place of service code for professional claims - 23 (Emergency Room)

b. Count only one visit per member per day

c. Child must be <21 years on date of visit

d. Identify an ED visit as being caries related if:

i. any of the ICD-9-CM diagnosis codes in Table 1 is listed as a FIRST-LISTED diagnosis code associated with the visit

OR

ii. (a) any of the ICD-9-CM diagnosis codes in Table 2 is listed as a FIRST-LISTED diagnosis AND (b) any of the ICD-9-CM diagnosis codes in Table 1 is listed as an ADDITIONAL LISTED diagnosis. (Codes from Table 2 must be accompanied by a code from Table 1 to qualify.)

e. Sum the number of ED visits for caries-related reasons.

Reporting note for age stratifications: Numerator cases are stratified based on age on date of ED visit.

YOU NOW HAVE NUMERATOR (NUM) COUNT: Number of ED visits for caries-related reasons

4. Stratify the numerator by whether visit resulted in an inpatient admission or did not result in an inpatient admission:

a. Identify a caries-related ED visit as resulting in an inpatient admission if:

(i) the patient has an inpatient admission defined by UB Type of Bill = 11x OR 12x OR 41x

AND

(ii) that admission occurred within 48 hours:

[inpatient admit date] – [ED admit date] ≥ 0 days AND <= 2 days

b. Sum the number of caries-related ED visits that resulted in an inpatient admission.

You now have the numerator stratum: caries-related ED visits that resulted in an inpatient stay.

c. Identify caries-related ED visits not resulting in an inpatient admission:

[total caries-related ED visits]–[caries-related ED visits resulting in inpatient admission]

You have the numerator stratum: caries-related ED visits that did not result in an inpatient stay.

5. Report

a. Unduplicated number of ED visits in the numerator

b. Unduplicated number of member months in denominator

c. Rate per 100,000 member months: (NUM/DEN) x 100,000

d. Rates for ED visits resulting in an inpatient stay and those not resulting in an inpatient stay

Table 1. Dental Caries-Related ICD-9-CM Diagnosis Codes

Note: The corresponding ICD-10 codes are provided in the attached Excel file that has the Data Dictionary Code Table associated with S.2b. above.

521.00 UNSPECIFIED DENTAL CARIES

521.01 DENTAL CARIES LIMITED TO ENAMEL

521.02 DENTAL CARIES EXTENDING INTO DENTINE

521.03 DENTAL CARIES EXTENDING INTO PULP

521.04 ARRESTED DENTAL CARIES

521.05 ODONTOCLASIA

521.06 DENTAL CARIES PIT AND FISSURE

521.07 DENTAL CARIES OF SMOOTH SURFACE

521.08 DENTAL CARIES OF ROOT SURFACE

521.09 OTHER DENTAL CARIES

522.0 PULPITIS

522.1 NECROSIS OF THE PULP

522.2 PULP DEGENERATION

522.3 ABNORMAL HARD TISSUE FORMATION IN PULP

522.4 ACUTE APICAL PERIODONTITIS OF PULPAL ORIGIN

522.5 PERIAPICAL ABSCESS WITHOUT SINUS

522.6 CHRONIC APICAL PERIODONTITIS

522.7 PERIAPICAL ABSCESS WITH SINUS

522.8 RADICULAR CYST

522.9 OTHER AND UNSPECIFIED DISEASES OF PULP AND PERIAPICAL TISSUES

525.3 RETAINED DENTAL ROOT

525.60 UNSPECIFIED UNSATISFACTORY RESTORATION OF TOOTH

525.61 OPEN RESTORATION MARGINS

525.63 FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL

525.64 FRACTURED DENTAL RESTORATIVE MATERIAL WITH LOSS OF MATERIAL

525.8 OTHER SPECIFIED DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES

525.9 UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES

526.4 INFLAMMATORY CONDITIONS OF JAW

526.5 ALVEOLITIS OF JAW

526.61 PERFORATION OF ROOT CANAL SPACE

526.62 ENDODONTIC OVERFILL

526.63 ENDODONTIC UNDERFILL

526.69 OTHER PERIRADICULAR PATHOLOGY ASSOCIATED WITH PREVIOUS ENDODONTIC TREATMENT

528.3 CELLULITIS AND ABSCESS OF ORAL SOFT TISSUES

Table 2. Additional First-Listed ICD-9-CM Diagnosis Codes to Identify Caries-Related Visits when Paired with an Additional Listed Diagnosis Code from the Caries-Related ICD-9-CM Codes in Table 1

Note: The corresponding ICD-10 codes are provided in the attached Excel file that has the Data Dictionary Code Table associated with S.2b. above.

682.0 CELLULITIS AND ABSCESS OF FACE

- must be paired with additional diagnosis code from Table 1

682.1 CELLULITIS AND ABSCESS OF NECK

- must be paired with additional diagnosis code from Table 1

682.9 CELLULITIS AND ABSCESS OF UNSPECIFIED SITES

- must be paired with additional diagnosis code from Table 1

782.3 EDEMA

- must be paired with additional diagnosis code from Table 1

784.2 SWELLING MASS OR LUMP IN HEAD AND NECK

- must be paired with additional diagnosis code from Table 1 Available at measure-specific web page URL identified in S.1

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5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable

5b.1 If competing, why superior or rationale for additive value: Not applicable

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

STATUS

Standing Committee Review

STEWARD

American Dental Association on behalf of the Dental Quality Alliance

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.

TYPE

Process

DATA SOURCE

Administrative claims Not applicable

No data collection instrument provided Attachment Copy_of_ICD-9_code_conversions-635569157171052184.xlsx

LEVEL

Integrated Delivery System

SETTING

Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance

TIME WINDOW

Data is aggregated for 12 months for both denominator and numerator.

Denominator time frame to identify ED visits: January 1 – December 1 of reporting year

Numerator time frame to identify follow-up visits: January 1 – December 31st

Denominator period is decreased by 30 days to allow 30-day follow up period within the same reporting year.

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

NUMERATOR DETAILS

Please see Section S18

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).

DENOMINATOR DETAILS

Please see section S18.

EXCLUSIONS

The following standard exclusion is applied: Medicaid programs should exclude children who do not qualify for EPSDT benefits.

EXCLUSION DETAILS

There are no other exclusions than those described above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

Not applicable – no risk adjustment for this measure.

STRATIFICATION

This measure will be stratified by age using the following categories:

<1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20

No new data are needed for this stratification. Please see attached specifications for complete measure details.

These stratification categories are consistent with other recently NQF-endorsed dental measures (NQF#2511; NQF#2517). Collapsed categories were considered; however, expert consensus concluded that given the different patterns between programs, a more refined approach would be more informative to measure implementers.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Follow-Up after Emergency Department Visit by Children for Dental Caries Calculation:

1. Run records for one reporting year for paid claims
2. Identify all emergency department visits for caries-related reasons occurring during eligible member months between January 1 and December 1 of the reporting year:

a. Identify a health care encounter as an ED visit if any of the following are met:

- CPT codes 99281-99285 (ED visit for patient evaluation/management); OR
- Revenue code 0450-0459 (Emergency Room) or 0981 (professional fees for ER services); OR
- CMS place of service code for professional claims - 23 (Emergency Room)

b. Exclude visits that result in inpatient admissions where inpatient admissions are identified as:

(i) the patient has an inpatient admission defined by UB Type of Bill = 11x OR 12x OR 41x

AND

ii) that admission occurred within 48 hours:

[inpatient admit date] – [ED admit date] ≥ 0 days AND <= 2 days.

c. Count only one visit per member per day

d. Member must be <21 years on date of visit

Reporting note: Age stratifications will be based on subject's age on date of ED visit.

e. Identify an ED visit as being caries related if:

i. any of the ICD-9-CM diagnosis codes in Table 1 is listed as a FIRST-LISTED diagnosis code associated with the visit

OR

ii. (a) any of the ICD-9-CM diagnosis codes in Table 2 is listed as a FIRST-LISTED diagnosis AND (b) any of the ICD-9-CM diagnosis codes in Table 1 is listed as an ADDITIONAL LISTED diagnosis. (Codes from Table 2 must be accompanied by a code from Table 1 to qualify.)

f. Member must be enrolled on date of ED visit and through 30 days following the visit.

g. Sum the number of ED visits for caries-related reasons

YOU NOW HAVE THE DENOMINATOR: Number of ED Visits for caries-related reasons

Table 1. Dental Caries-Related ICD-9-CM Diagnosis Codes

Note: The corresponding ICD-10 codes are provided in the attached Excel file that has the Data Dictionary Code Table associated with S.2b. above.

521.00 UNSPECIFIED DENTAL CARIES

521.01 DENTAL CARIES LIMITED TO ENAMEL

521.02 DENTAL CARIES EXTENDING INTO DENTINE

521.03 DENTAL CARIES EXTENDING INTO PULP

521.04 ARRESTED DENTAL CARIES

521.05 ODONTOCLASIA

521.06 DENTAL CARIES PIT AND FISSURE

521.07 DENTAL CARIES OF SMOOTH SURFACE

521.08 DENTAL CARIES OF ROOT SURFACE

521.09 OTHER DENTAL CARIES

522.0 PULPITIS

522.1 NECROSIS OF THE PULP

522.2 PULP DEGENERATION

522.3 ABNORMAL HARD TISSUE FORMATION IN PULP

522.4 ACUTE APICAL PERIODONTITIS OF PULPAL ORIGIN

522.5 PERIAPICAL ABSCESS WITHOUT SINUS

522.6 CHRONIC APICAL PERIODONTITIS

522.7 PERIAPICAL ABSCESS WITH SINUS

522.8 RADICULAR CYST

522.9 OTHER AND UNSPECIFIED DISEASES OF PULP AND PERIAPICAL TISSUES

525.3 RETAINED DENTAL ROOT

525.60 UNSPECIFIED UNSATISFACTORY RESTORATION OF TOOTH

525.61 OPEN RESTORATION MARGINS

525.63 FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL

525.64 FRACTURED DENTAL RESTORATIVE MATERIAL WITH LOSS OF MATERIAL

525.8 OTHER SPECIFIED DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES

525.9 UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES

526.4 INFLAMMATORY CONDITIONS OF JAW

526.5 ALVEOLITIS OF JAW

526.61 PERFORATION OF ROOT CANAL SPACE

526.62 ENDODONTIC OVERFILL

526.63 ENDODONTIC UNDERFILL

526.69 OTHER PERIRADICULAR PATHOLOGY ASSOCIATED WITH PREVIOUS ENDODONTIC TREATMENT

528.3 CELLULITIS AND ABSCESS OF ORAL SOFT TISSUES

Table 2. Additional First-Listed ICD-9-CM Diagnosis Codes to Identify Caries-Related Visits when Paired with an Additional Listed Diagnosis Code from the Caries-Related ICD-9-CM Codes in Table 1

Note: The corresponding ICD-10 codes are provided in the attached Excel file that has the Data Dictionary Code Table associated with S.2b. above.

682.0 CELLULITIS AND ABSCESS OF FACE

- must be paired with additional diagnosis code from Table 1

682.1 CELLULITIS AND ABSCESS OF NECK

- must be paired with additional diagnosis code from Table 1

682.9 CELLULITIS AND ABSCESS OF UNSPECIFIED SITES

- must be paired with additional diagnosis code from Table 1

782.3 EDEMA

- must be paired with additional diagnosis code from Table 1

784.2 SWELLING MASS OR LUMP IN HEAD AND NECK

- must be paired with additional diagnosis code from Table 1

3. Check if subject had a visit with a dentist (dental service) within 30 days of the ED visit:

a. If CDT [SERVICE-CODE] = D0100 – D9999 (any dental service), AND;

b. [DATE OF ED VISIT]-[DATE OF DENTAL VISIT] <=30 days;

Note: If two or more caries-related ED visits occur for same child within 30 days of one another, then use the first ED visit as the index date for follow-up. Both ED visits will count in the denominator. A follow-up dental visit within 30 days of the first ED visit will be counted once in the numerator.

AND;

c. If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table 3 below, then proceed to next step (#4).

d. If a AND b AND c are not met, then the service was not a "follow-up dental service" STOP processing. This ED visit is already included in the denominator but will not be included in the subsequent counts.

Note: In this step, all claims with missing or invalid SERVICE-CODE, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table 3 should be excluded.

YOU NOW HAVE NUMERATOR 2 (NUM2): ED visits for caries-related reasons for which the child had a visit with a dentist within 30 days

4. Among the ED visits identified in Step 3, check if the subject had a visit with a dentist (dental service) within 7 days of the ED visit:

[DATE OF ED VISIT]-[DATE OF DENTAL VISIT] <=7 days

YOU NOW HAVE NUMERATOR 1 (NUM1): ED visits for caries-related reasons for which the child had a visit with a dentist within 7 days

5. Report

a. Unduplicated count of caries-related ED visits with 30-day dentist visit follow-up in numerator

b. Unduplicated count of caries-related ED visits with 7-day dentist visit follow-up in numerator

c. Unduplicated count of caries-related ED visits in denominator

d. Rates: (NUM1/DEN), (NUM2/DEN)

Table 3: NUCC maintained Provider Taxonomy Codes classified as dentist*

122300000X	1223P0106X	1223X0008X	261QF0400X
1223D0001X	1223P0221X	1223X0400X	261QR1300X
1223D0004X	1223P0300X	124Q00000X+	
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

*Services provided by County Health Department dental clinics may also be included as "dental" services.

+Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services.

*** Note: Reliability of the measure score depends on quality of the data that is used to calculate the measures. Flow rates (% of missing or invalid data) for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid SERVICE-CODE will be counted in the "all enrollees" but not in "all enrollees who received service". These records are assumed to not have had a visit. In this case, a low

quality data set will result in a low score and will not be reliable.*** Available at measure-specific web page URL identified in S.1

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5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable

5b.1 If competing, why superior or rationale for additive value: Not applicable

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ISBN 978-0-9828420-8-9