NATIONAL QUALITY FORUM

Memo

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: *NQF-Endorsed Measures for Health and Well-Being Phase 2*

DA: July 22, 2015

NQF Member Voting

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on August 5, 2015 at 6:00 pm ET – no exceptions.

Background

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

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

Comments Received

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

Pre-evaluation comments

For this evaluation cycle, the pre-evaluation comment period for the seven measures under review was open from March 4, 2015 until March 24, 2015. Four pre-evaluation comments were received from the Children's Hospital Association. These comments pertained to the two dental measures, #2689 *Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children* and #2695 *Follow-Up after Emergency Department Visit by Children for Dental Caries* and the two measures examining developmental screening, #1448 *Developmental Screening in the First Three Years of Life* (rescheduling the maintenance review) and #1385 *Developmental screening using a parent completed screening tool (Parent report, Children 0-5)*. The commenter encouraged NQF to consider aligning the measures under review with measures newly-developed or under development through the Pediatric Quality Measures Program.

All pre-evaluation comments were provided to the Committee prior to its deliberations during the In-Person Meeting.

Post-evaluation comments

The Draft Report was posted for Member and public comment from May 29, 2015, through June 29, 2015. During this comment period, NQF received 37 comments from six Member organizations and several members of the public:

Consumers – 0	Professional – 1
Purchasers – 0	Health Plans – 1
Providers – 2	QMRI – 1
Supplier and Industry – 0	Public & Community Health – 1

A complete table of comments submitted pre- and post-evaluation, along with the responses to each comment and the actions taken by the Standing Committee, is posted to the project page on the NQF website, along with the measure submission forms.

The Committee reviewed the comments received and considered the pre-meeting comments prior to making an endorsement recommendation. The Committee also reviewed and acknowledged all post-evaluation comments. Revisions to the draft report and the accompanying measure specifications are identified as red-lined changes. (Note: Typographical errors and grammatical changes have not been red-lined, to assist in reading.)

Comments and Their Disposition

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

1. Implementation Issues
2. Concerns about measure focus
3. NQF revised pneumococcal vaccination standard specifications

Theme 1 – Implementation Issues

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

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

Two similar comments regarding measure 2689 questioned whether this measure will apply across health systems or only to Medicaid patients, there is an underlying assumption that emergency department visits for dental caries implies the existence of unaddressed disease. The commenters further indicated that symptoms of severe caries can be treated by antibiotics in a primary or urgent care center. One commenter supported this measure and noted that the need for this measure is likely a result of the health system's failure to prevent and proactively treat/manage oral health caries in children, which would reduce the frequency of future ED visits.

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

Theme 2 – Concerns about Measure Focus

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

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

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

Theme 3 – NQF Revised Pneumococcal Vaccination Standard Specifications

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 one 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 standards and decision to defer measures based on changing evidence related to pneumococcal standards.

Measure-Specific Comments

Measures Recommended

0280: Dehydration Admission Rate (PQI 10)

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.

Developer Response:

"The purpose of the PQIs is to identify potentially preventable hospitalization. In the case of dehydration, hospitalizations may be preventable through access to community based care for high risk patients to prevent dehydration, identify and treat dehydration early before it requires hospitalization or proactive interventions for individuals at very high risk for dehydration (e.g. post gastrointestinal surgery). The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. The PQI are not designed to identify "inappropriate" hospitalizations, nor to imply that the hospitalizations captured are mild enough to be treated in an ambulatory setting. Many of the hospitalizations captured by the PQI are clinically indicated. The preventability is further upstream, before a patient develops a severe clinical state requiring hospitalization."

"The PQI 10 indicator for dehydration was developed to provide insight into the community health care system or services outside the hospital setting. Even though there is a wide spectrum of underlying conditions related to dehydration, there is evidence that with high-quality, community-based primary care, a portion of hospitalizations can be avoided. The indicator is defined, tested, validated and endorsed at the geographic area (county and larger) level. The PQIs can be used to help flag geographic areas that need further investigation; provide a check of community-level health care resources, evaluate hospital utilization, and to provide insight on burden of illness. In 2009 AHRQ explored alternative specifications of the PQI which would measure quality and access to care for health plan populations or large physician groups

(Davies et al, 2011, Med Care 49(8)). Incidentally, the panels recommended that the "dehydration" be adapted to measure quality of care for long term care facilities. However, AHRQ has not, tested or otherwise implemented the alternative specifications for health plans, large physician groups or long-term care facilities as part of the AHRQ QI program."

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

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.

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."

1407: Immunizations for Adolescents

This measure received four comments, all supporting the Committee's recommendation of endorsement for the measure.

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

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.

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."

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

This measure received seven comments. The majority of the comments supported the Committee's recommendation to endorse the measure. A set of two similar comments pointed to the underlying assumption that emergency department visits for dental caries implies unaddressed disease and requested that the developer should specifically define how they intend to assess the severity of the unaddressed disease through any care mechanism.

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."

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

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

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."

Measure Not Recommended

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

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 validated screening tools.