TO: Health and Well-Being Standing Committee

FR: NQF Staff

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

DA: December 6, 2016

Purpose of the Call

The Health and Well-Being Standing Committee will meet via conference call on Tuesday, December 6, 2016, from 2:00-4:00pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Due to time constraints, the Committee will focus on comments/responses for the "consensus not reached" measures. We will also review comments and responses by exception for those measures for which the Committee already reached consensus at the in-person meeting (recommend, did not recommend, or approved for trial use)—i.e., for these measures we will assume the Committee is fine with its original decision and the proposed response to any comments to that decision unless a Committee member seeks new discussion on the call.

NQF staff has drafted responses to the comments. Committee members should review all comments and draft responses prior to the call.

Standing Committee Actions

1. Review this Comment and Voting Memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

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

Speaker dial-in #: (888) 799-0466 (*NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?602725
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?602725

Background

Social, environmental, and behavioral factors can have significant negative impact on health outcomes and economic stability. These factors and other upstream determinants contribute to 60 percent of deaths in the United States; yet only three percent of national health expenditure

is spent on prevention, while 97 percent is spent on healthcare services. Developing strategies to strengthen the measurement and analysis of health and well-being, given its multi-dimensional focus, can be best 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 reducing mortality and excess morbidity and help focus future work to improve population health in appropriate areas.

On September 12-13, 2016, the Health and Well-Being Standing Committee evaluated 12 newly-submitted measures and 11 measures undergoing maintenance review against NQF's standard evaluation criteria. Ten measures were recommended for endorsement, three measures were recommended for Trial Use, one measure was recommended for inactive endorsement with reserve status, and the Committee did not reach consensus on six measures. Additionally, the Committee did not recommend three measures.

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

The pre-evaluation comment period was open from August 10 through August 23, 2016 for all measures except *NQF 0279: Bacterial Pneumonia Admission Rate (PQI 11)*, which was assigned to the project after that period. Additionally, *NQF 3062: Hypertension Screening for Children Who Are Overweight or Obese* was available for pre-evaluation comment but was withdrawn prior to final Committee evaluation. No comments were received on any measure during this preliminary commenting period.

Post-evaluation comments

The Draft Report was available for member and public comment between October 24 through November 22, 2016. During this commenting period, NQF received 166 comments from 10 member organizations and comments from 11 organizations/individuals that are not NQF members:

Consumers – 0	Professional – 0
Purchasers – 1	Health Plans – 4
Providers – 0	QMRI – 3
Supplier and Industry – 3	Public & Community Health - 7

To facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the measures for which consensus was not reached (CNR) and/or those measures with other issues that arose from the comments. Note that the organization of the comments into major categories is not an attempt to limit Committee discussion.

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

Comments and their Disposition

Five major categories were identified in the post-evaluation comments, as follows:

1. Support for endorsement of CNR measure(s)
2. Disagreement with Committee recommendation
3. Support for Committee recommendation
4. General recommendation to Committee or support for report
5. Recommendation to developer (e.g., re: specifications)

Additionally, as discussed at the in-person meeting, NQF staff worked with the developer on the additional testing information for *NQF 0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay).* This measure is discussed as the first item under "Theme 1" because it is a measure for which consensus was not reached. The additional testing information is provided as Attachment 1.

Theme 1 - Support for endorsement of CNR measure

The 90 comments categorized under this area were submitted to provide additional information about or general support for measures where consensus was not reached; of note, several were multi-part comments (owing to NQF's character limitation), so the actual number of commenting organizations/individuals was 27. In addition to the information related to #0680, we categorized the comments for CNR measures in three groups: HIV viral load suppression (#3086)[1]; childhood immunization status (#0038); and three nutrition-related measures (#3087, #3088, #3089).

[1] Because the commenter/developer (CDC) experienced difficulty with the on-line portal that could not be resolved by the deadline, the developer forwarded comments as Word and PDF files. We are working with CDC to ensure the comments are ultimately populated in the NQF database, but at this time we refer the Committee to Attachment 2 for this material, and not the Excel comment table.

#0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Centers for Medicaid and Medicare Services) (Submission | Specifications)

The Committee did not reach consensus on Reliability and Validity. The developer had provided inter-rater reliability results using the nursing home database (MDS), but testing was not conducted on the reliability of the influenza measure items from the LTCH Care Data Set or the IRF-PAI. The developer had stated that it was reasonable to apply the reliability testing from the MDS to the LTCH CARE Data Set and the IRF-PAI, but also noted the populations are not identical and some differences in reliability may exist. The developer agreed to work with NQF staff following the in-person meeting to clarify the concerns about testing.

The developer provided the additional material aa Attachment 1. NQF staff has reviewed this material and note the following:

- For the nursing home (NH), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) settings, the developer submitted a detailed explanation of testing methods, score-level reliability testing results, including analyses of variance and confidence interval.
    - For Reliability, the developer conducted measure score reliability testing for NH, IRF and LTCH settings. Using signal to noise analysis, the developer assessed the ratio of variance between facilities and the variance within facilities (patient or resident measure scores compared to the facility-level mean of those scores) to discern statistically significant differences in performance on the measure due to facility quality ("signal") rather than resident- or patient-level factors ("noise"). In this case, the η2 statistics measured the ratio of the variance attributable to facility-level differences to all variance associated with patient or resident level vaccination rates. The observed η2 statistics were .17 for IRFs, .37 for LTCHs, and .18 in the NH setting.
    - For Validity in the IRF and LTCH settings, the developer conducted construct validation at the measure score level and clearly described its hypotheses, expected results and analysis. Overall results were in the expected direction although not statistically significant. However, when "receive vaccine" vs. "decline vaccine" were separated, the results were in the expected directions and there was statistical significance for the IRF setting for both (only for "receive vaccine" in the LTCH setting). Results for the contraindication were not statistically significant, and were in the wrong direction for IRFs.
    - If the Committee considers the developer's additional score-level reliability testing, the highest eligible rating based on the algorithm is HIGH. If the Committee considers the construct validity for the IRF and LTCH settings, the highest eligible rating is HIGH.

Action Item: After review of the additional material, the Committee will re-vote on the *Reliability and Validity* criterion and, if consensus is reached on both, overall suitability for endorsement.

#3086: Population Level HIV Viral Load Suppression (Centers for Disease Control and Prevention) (Submission | Specifications)

The Committee did not reach consensus on Reliability and Validity. For reliability testing, the developer cited state law and quality control for its data and did not provide any empirical testing at the score- or data element-levels, as is required by NQF. It was noted that, during the technical assistance phase of the project, NQF had recommended that the developer assess state audit data and related inputs, where available, to determine reliability and validity; literature or information directly from states was suggested. Committee members also recommended that the developer identify the "gold standard" – data audit of viral load captured in the CDC surveillance system against state records.

- In commenting on the measure,[2] CDC further described the internal and state-based quality assurance systems related to completion and other data quality control and provided data related to these activities. CDC also provided specific literature as originally suggested may be used to assess empirical reliability and validity testing. CDC posited that CDC and states continue to invest in strengthening state HIV surveillance and so the published data should be viewed as conservative estimates of reliability and validity.
- **For reliability**, CDC specifically presents data from an article (Dixon, 2013) that addresses the validity at the data element level (may be used for reliability under the NQF algorithm) of the state's data (electronic lab data then transmitted to CDC) as compared to the gold standard of the patient's medical record.
    - The study of electronic lab reporting in Indiana and Wisconsin reported 98% or greater completeness rates (2010 data) in both states for the following data elements: patient identifier, patient name, patient date of birth, patient sex, test name, and test results. CDC notes that these elements speak to the utility of the lab report for generating new, or updating existing, HIV case records and state-level viral load suppression results. CDC did not report whether the paper provided additional statistical analyses (kappa, PPV, NPV, sensitivity, specificity).
    - Based on the algorithm reliability/validity testing at the data-element level, the highest eligible rating is MODERATE.
- **For validity**, CDC presents data from three published articles and unpublished data to address potential validity issues of data from multiple sources (recall that, depending on the system, some states have e-lab reporting or manual entry or a mix); duplicate counting; and construct validity examining surveillance data as compared to measures derived from the medical record (Subharwal, 2014) or a medical record abstraction project CDC supports in Georgia. The threats to validity are encompassed in the first two articles, and find:
    - CDC reports that a 2014 paper by Dombrowski et al. found no meaningful difference among King County (Washington) viral load suppression rates in samples from chart review, CDC-funded Medical Monitoring Project (MMP;

[2] Again, the comments are provided at Attachment 2 at this time and in the spreadsheet because of portal difficulties.

chart review and interview), and the surveillance system: 59% from both chart review and adjusted MMP, and 57% from surveillance.

- One source of bias in the viral load suppression state results could arise from the denominator, wherein people living with HIV may move from the state in which they are diagnosed to a new one. CDC reports that >95% of duplicates are resolved within 18 months; however, the measure timeframe is 12 months. CDC notes, however, that a recent paper by Ocampo et al. (2016) suggests that annual migration is low and that a new approach described by the paper (taking minutes) will further improve denominator bias.
- CDC states that the Subharwal paper provides evidence that the "retention in care" measure results (from New York City surveillance data) align with scores calculated on the basis of data available from medical records. Specifically, CDC reports the paper finds that the sustained and continuous care measures exhibit agreement of >85%. NQF staff note that the paper speaks to the underlying data elements of the surveillance vs. medical record and, while somewhat indirect, relates to construct validity of measure scores (i.e., similar measure scores result from both, as hypothesized). (A direct relationship/empirical testing would have been #3086 as it correlates to the two "retention in care" measures.)
- If the Committee considers the Subharwal sufficient score-level testing, the highest eligible rating based on the algorithm is HIGH. If the Committee considers face validity (previously reported) and data element validity (but not sufficient demonstration of score level), the highest eligible rating is MODERATE.

Action Item: After review of the comments, the Committee will re-vote on the *Reliability and Validity* criterion and, if consensus is reached on both, overall suitability for endorsement.

#0038: Childhood Immunization Status (CIS) (National Committee for Quality Assurance)
(Submission | Specifications)
The Committee did not reach consensus on the Composite Quality Construct and Rationale. The Committee stressed the importance of assessing individual components, but some Committee members expressed reservations about the all-10 composite. After the in-person meeting, the developer asked that the all-10 composite be withdrawn from consideration as part of #0038.

The developer submitted a comment requesting that language related to disparities data for this measure (and its other measures) be revised to indicate that NCQA will "consider" pursuing working with health plans or reviewing national data in order to provide disparities information in the next update. NQF staff confirmed, via notes and the meeting transcript, the accuracy of the language in the report that the developer *agreed* to pursue this information. Lastly, the developer proposed edits related to clarifying the source of statements related to its cervical cancer screening measure (#0032).

Action Item: Because the other criteria were met, the Committee will vote on overall suitability for endorsement.

Proposed Committee Response: Retain the disparities language to reflect an agreement to pursue unless the developer asks to reconsider that agreement and only commit to "consider pursuing". Clarifying edits related to #0032 will be incorporated.

#3087: Completion of a Malnutrition Screening within 24 hours of Admission (Academy of Nutrition & Dietetics/Avalere) (Submission | Specifications)
#3088: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening (Academy of Nutrition & Dietetics/Avalere) (Submission | Specifications)
#3089: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment (Academy of Nutrition & Dietetics/Avalere) (Submission | Specifications)
The Committee did not reach consensus on Evidence for #3087 and #3088 and for Validity on #3089. Forty comments (some multi-part) were received from 23 organizations/individuals and the developer for #3087, 39 comments from 23 organizations/individuals and the developer for #3088, and 30 comments from 18 organizations/individuals and the developer for #3089. The comments were largely repetitive and supplied the same, or nearly so, list of references. Many of the references were part of the original submission and addressed findings that malnourished patients have increased lengths of stays, increased mortality, and other adverse health outcomes but were not specific to the measure foci (screening, completion of assessment, care plan). In the sections that follow, the Committee's original decision is first presented, followed by a summary of what appeared to be the most salient information by the commenters and developers. Committee members are referred to the Comment Table for all comments.

For #3087, Committee members raised concern about the burden of screening each hospitalization (patients 18 and older) within 24 hours, regardless of patient risk or condition, as well as whether the screening to treatment link was substantiated by evidence. (Specific concerns with the 2011 American Society for Parenteral and Enteral Nutrition guidelines (Grade C) and the lack of requirement for a standardized tool, which the developer indicated was difficult at this time, as well as institutional variability (who does screening, with what tool, etc.)). The Committee did not reach consensus on Evidence for #3087. For #3088, Committee members debated whether the number of studies in the observation and randomized trials mentioned in the 2011 American Society for Parenteral and Enteral Nutrition guidelines (Grade E) were sufficient and able to discern the risk of bias; the Committee failed to reach consensus on the Evidence criterion for #3088. For #3089, the Committee did not achieve consensus on Validity, expressing concerns about the omission of exclusions, as well as variability of treatment protocols.

- In commenting on the measure, the developer notes it submitted a series of four measures that, in part, build on each other. Specifically, with respect to screening, the developer posits that #3087 triggers all subsequent care, noting the numerator for this measure becomes the denominator for #3088. The developer expresses concern that the lack of the initial universal screening (#3087) measure may lead to uneven implementation (i.e., ad hoc identification of the denominator) of the other measures.

- No additional information was provided through the comments linking screening to treatment/outcomes.
- A few commenters noted that malnutrition screening within 24 hours of admission had been a Joint Commission (TJC) standard for many years. One commenter noted that the TJC recently removed the standard, citing that it "addresses routine part[s] of operations or clinical care processes." The commenter noted, however, there are no quality measures in place to reliably evaluate such performance. A comment by TJC "welcomes" performance measures to assess the degree that screening occurs.
- As noted, most of the references overlapped with those in the submission or did not directly address the measure focus/specifications to improvement. NQF staff did examine further two 2016 articles commenters cited. Based on the publication date, these appeared to be available during the submission timeframe, but we did not identify them in a "search" of the original submission:
    - An April 2016 article (Kruizenga) notes that Dutch hospitals are required to screen for undernutrition on the first day of admission. One of two standardized instruments were used; study size was 564,063 patients from 2007-2014. Patients who had an undernourished screening score had a higher LOS than did patients who did not (median 6.8 compared with 4.0 d; $P < 0.001$). One out of 7 patients was scored as undernourished. For geriatrics, oncology, gastroenterology, and internal medicine, this ratio was even greater (1 out of 3–4). Hospital stay was 1.4 d longer among undernourished patients than among those who were well nourished. The study confirms other literature that reports that patients who are malnourished have longer LOS, but in this case specifically identified the patients through the use of a standardized screening tool.
    - The other 2016 article (Allard) merely points to other similar articles that malnutrition at admission "is prevalent and associated with prolonged LOS." Patients first underwent "the main nutrition evaluation was subjective global assessment (SGA). Body mass index (BMI) and handgrip strength (HGS) were also performed to assess other aspects of nutrition." 1,500 pts enrolled in study, 45% found to be malnourished and LOS was found to be increased in that population. Screening of all patients per se is not addressed.
- Regarding the Committee's concern about the burden of screening each hospitalization, a recommendation to endorse #3087 is argued by commenters that the burden is "low." A standardized 2-item questionnaire is cited as evidence of low burden; as noted during the in-person, the measure does not require a standard instrument.
- Several commenters cited an AHRQ statistical brief released after the Committee meeting (September 20, 2016), which characterizes hospital stays involving malnutrition, but which does not address whether the specific aspects of the measure specifications per se link to improved quality (i.e., screening, nutritional assessment, follow-up plan of care and documentation). Weiss AJ, et al. Characteristics of Hospital Stays Involving Malnutrition, 2013. HCUP Statistical Brief #r 210. September 2016.

Agency for Healthcare Research and Quality, Rockville, MD. A copy of this new brief is provided as Attachment 3.

- For #3088 (completion of a nutrition assessment once identified as at-risk), commenters again largely cite literature previously included or that do not directly link the completion to outcome. The Allard (2016) article also is cited as "new" evidence. Again, the focus of the Allard article appears to be confirmatory evidence that malnutrition at admission is associated with increased LOS, not that completing a nutrition assessment reduced LOS.
- Finally, for #3089 (documentation of a care plan for patients found to be malnourished based on a complete nutrition assessment), for which the Committee did not achieve consensus on validity, the commenters and developer again recommend the Committee advance the measure. No comments appear to address the Committee's concerns about the omission of exclusions. Regarding concerns about variability, one of the organizations (measure steward) (Hoggle, Academy of Nutrition & Dietetics on behalf of Informatics & Interoperability Committees) notes that its committees are working to ensure that terms from the Academy's Nutrition Care Processes (NCP) are mapped to clinical terminologies such as SNOMED-CT® and LOINC®. The comment notes, "upon malnutrition screening and appropriate assessment of at-risk patients, the nutrition intervention is developed using the NCP. Use of appropriate malnutrition language and terminologies (via the mapping of eNCPT to clinical and/or reimbursement terminologies), the intervention can be included in the electronic Care Plan. Selection of appropriate terminology possible for a problem-etiology-signs/symptoms documentation allows for structured coded data which is consistent with other areas of an EHR."

Action Items: After review of the comments for #3087 and #3088, the Committee will vote on Evidence and, if consensus is reached, on overall suitability for endorsement. For #3089, the Committee will vote on Validity and, if consensus is reached, on overall suitability for endorsement.

Theme 2 – Disagreement with Committee recommendation

Six comments (some multi-part) were received from two organizations/individuals on the following four measures:

- Influenza vaccination measures #0039 (NCQA), #0041 (PCPI Foundation), and #3070 (PCPI Foundation eMeasure version of 0041) were recommended by the Committee, but the American Academy of Family Physicians opposes these measures because they have not been included in the Core Measures Set for ACO/PCMH/Primary Care; concern also is expressed about the numerator specifications. The American Academy of Pediatrics does not explicitly oppose #0041 and #3070, but expressed concern that the specifications do not align with its recommendations for influenza vaccinations for patients 6 months to 8 years.
- As with the other nutrition-related measures, several commenters disagreed with the Committee's decision not to recommend #3090 (documentation of malnutrition diagnosis). The Committee failed the measure on Evidence. No new evidence is offered that links documentation of the diagnosis to improved outcomes, but the developer

asks the Committee to consider granting an Exception to the Evidence—i.e., does the Committee agree that it is OK (or beneficial) to hold providers accountable for performance in the absence of empirical evidence of benefits to patients?

Proposed Committee Response: NQF appreciates your comment, which the Committee will consider on its post-comment call. [To be edited if the Committee does change its previous decision.]

Theme 3 - Support for Committee recommendation

Nine comments from five organizations were submitted in support of the Committee's recommendations to endorse the following five measures: *#0226: Influenza Immunization in the ESRD Population; #0032: Cervical Cancer Screening (CCS); #3060: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (Trial Use)*; *#0431: Influenza Vaccination Coverage Among Healthcare Personnel; #0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay); #2828: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan.* Some measures received support from more than one organization/individual.

Proposed Committee Response: NQF appreciates your comment.

Theme 4 – General comments on the report/project

Three comments from three organizations were submitted in general support of the effort of the report and project.

Proposed Committee Response: NQF appreciates your comment.

Theme 5 – Comments directed to the developer

Nine comments from three organizations/individuals disagreed with the developer's specifications or recommended that the developer consider revisions in future iterations. The seven measures for which developer response was specifically sought are*: #0039: Flu Vaccinations for Adults Ages 18 and Older (National Committee for Quality Assurance); #0041: Preventative Care and Screening Influenza Immunization (PCPI); #0279: Bacterial Pneumonia Admission Rate (Agency for Healthcare Research and Quality); #0431: Influenza Vaccination Coverage Among Healthcare (Centers for Disease Control and Prevention); #2828: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Quality Insights Pennsylvania); #3059: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (PCPI); #3070: Preventative Care Screening: Influenza Immunization (PCPI).*

Developer Response for #0039:

- This measure is specified and tested at the health plan and integrated system level of accountability. Flu shots are provided in a variety of acceptable settings (physician office, pharmacy, retail pop-up clinics, public health, and work-sites) which necessitates a survey-based approach to measurement. The intent of this measure is to assess whether members are getting vaccinated seasonally regardless of the site of vaccination. We expect health plans to ensure all adults 18

years and older receive a flu vaccine. We recognize some patients should not receive the flu vaccine due to medical reasons; however, we anticipate this to be evenly distributed across plans. We also do not expect vaccine shortages to have a significant impact on health plan rates for flu vaccination.

Developer Response for #0041:

- This measure is based on the CDC's Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.

  The expert work group constructed this measure based primarily on the CDC's recommendation in addition to data on peak month flu activity. While seasonal influenza may be active year-round, the CDC states that peak flu activity is between October and March (http://www.cdc.gov/flu/about/season/flu-season.htm). Additionally, the flu season covered is aligned with other NQF endorsed flu vaccine measure and in alignment with NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations. Furthermore, the PCPI aims to develop broad measures in response to current national interest in the parsimonious use of measures to reduce the resource burden on health care providers without compromising the quality of patient care.

  Finally, regarding the AAP's concern about the availability of the influenza vaccine, the expert work group raised this issue and opted to include a measure exception when the vaccine is not available so as not to inappropriately penalize a clinician for an issue not within his/her control.

- This measure is based on the CDC's Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.

  Influenza may lead to serious complications and vaccination is the most effective protection against influenza virus infection. However, data indicate that less than half of all eligible individuals receive an influenza vaccination.

  This measure promotes annual influenza vaccination for all persons aged ≥ 6 months. The measure assesses whether a patient received the flu vaccine or reports previous receipt of the flu vaccine at any other location or via another provider. The measure does not account for patient counseling to receive the vaccine elsewhere because this does not ensure that the patient receives the vaccination thereby reducing the risk of adverse flu-related outcomes as is the intent of this measure.

Developer Response for #0279:

- AHRQ would like to clarify that this measure is intended to measure area-level access to care and community wellness, rather than the quality of physicians, hospitals or other provider groups. As such, higher rates in communities may reflect poorer health in the community, higher chronic disease burden and lower access to care. We observe disparities in populations with lower socioeconomic status, which simply highlights the need in such communities to improve the health of the population and the resources available to promote health in a community. When used as intended and tested, PQI 11 highlights communities in need rather than penalizing the physicians and hospitals in those areas. Possible mechanisms of community influence on hospitalization rates for pneumonia were discussed in the Health and Well Being Committee meeting and do span beyond the actions of any one physician. These mechanisms influence not only the vulnerability of patients in a population to develop pneumonia (e.g. Low access to vaccination) but also the resulting clinical severity of that pneumonia.

  AHRQ would like to clarify two additional aspects of PQI 11. The commenter does discuss presentation to the ED, but PQI 11 will capture these encounters only if the patient is then hospitalized. Second, the AHRQ PQI software includes two risk models. The default uses only age and gender of the population, while an optional model adds poverty to the model. As was noted in the NQF Committee on socioeconomic adjustment of quality measures, there are valid reasons to both adjust and not adjust for socioeconomic status. As such, AHRQ provides two models to meet various user needs.

Developer Response for #0431:

- NQF 0431 is based on the National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations published by the National Quality Forum in 2008. In this report, NQF notes that the issue of denominator exclusions for delays in influenza vaccine availability was discussed by its Steering Committee of experts. Ultimately, the Steering Committee did not include an exclusion for delays in influenza vaccine supply in the standard measure specifications because (a) there was no systematic and consistent way to implement this exclusion and (b) influenza vaccine supply issues have become less frequent. The Committee further noted that in the event of a declared shortage of influenza vaccine, all healthcare providers purchasing the vaccine in question would be affected and a measure with no exclusions could be useful in assessing any differential impact of the delay or shortage on different providers.

  The window for influenza vaccination (numerator) as measured by NQF 0431 begins as soon as vaccine for the current influenza season becomes available at the reporting facility and extends through March 31 of the following year. In the event

of small or brief delays in vaccine availability, the length of this time window should permit reporting facilities adequate time to vaccinate and report data on vaccination even if the process begins later than usual. In the event of a more substantial or lengthier supply interruption, it is likely that many or most reporting facilities would be affected and that influenza vaccine supply concerns would be taken into account by measurement programs and organizations when scoring the measure for that season.

Developer Response for #2828:

- Regarding data capture, measure testing revealed that structured fields documenting follow-up are available in some, but not all, EHRs. Quality Insights is currently reviewing options to improve data capture, but testing suggests that the measure is feasible, at least in some provider practices.

  The measure is intended to encourage clinicians to offer interventions to patients who are underweight, overweight, or obese, and clinicians from various specialties are eligible to report the measure. Furthermore, there are many follow-up approaches clinicians can use for these patient populations, each of which has varying levels of evidence. The measure therefore allows for a wide range of eligible follow-up plans. In future updates, we will consider codes for intensive obesity counseling to help address this issue. As more evidence becomes available to support specific follow-up plans that improve patient outcomes, we will update the measure accordingly.

  Finally, we are reviewing waist circumference measurement with an expert work group. We designed the measure to align with current clinical guidelines which recommend screening for obesity using BMI. The measure does not currently include waist circumference measurement as an alternative because it may not apply to all patients, such as underweight patients. We will continue to monitor clinical guidelines and update the measure accordingly.

Developer Response for #3059:

- No response received

Developer Response for #3070:

- This measure is based on the CDC's Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.

The expert work group constructed this measure based primarily on the CDC's recommendation in addition to data on peak month flu activity. While seasonal influenza may be active year-round, the CDC states that peak flu activity is between October and March (http://www.cdc.gov/flu/about/season/flu-season.htm). Additionally, the flu season covered is aligned with other NQF endorsed flu vaccine measure and in alignment with NQF's National Voluntary Consensus Standards for Influenza and Pneumococcal Immunizations. Furthermore, the PCPI aims to develop broad measures in response to current national interest in the parsimonious use of measures to reduce the resource burden on health care providers without compromising the quality of patient care.

Finally, regarding the AAP's concern about the availability of the influenza vaccine, the expert work group raised this issue and opted to include a measure exception when the vaccine is not available so as not to inappropriately penalize a clinician for an issue not within his/her control.

- This measure is based on the CDC's Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2016–17 Influenza Season. Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications.

  Influenza may lead to serious complications and vaccination is the most effective protection against influenza virus infection. However, data indicate that less than half of all eligible individuals receive an influenza vaccination.

  This measure promotes annual influenza vaccination for all persons aged ≥ 6 months. The measure assesses whether a patient received the flu vaccine or reports previous receipt of the flu vaccine at any other location or via another provider. The measure does not account for patient counseling to receive the vaccine elsewhere because this does not ensure that the patient receives the vaccination thereby reducing the risk of adverse flu-related outcomes as is the intent of this measure.