NATIONAL QUALITY FORUM

National Voluntary Consensus Standards for Patient Outcomes: Child Health

Conference Call of the Steering Committee

April 12, 2010
1:00 pm–3:00 pm (ET)

Steering Committee members participating: Charles Homer, MD, (co-chair); Marina Weiss, PhD (co-chair); Allan Lieberthal, MD; Bonnie Zima, MD, MPH; Lee Partridge; Donna Persaud, MD; David Clarke, MD; Ellen Schwalenstocker, PhD, MBA; Goutham Rao, MD; Faye Gary, EdD, RN; Kathy Jenkins, MD, MPH; Thomas McInerny, MD; Jane Perkins, JD, MPH; Phillip Kibort, MD, MBA; Nancy Fisher, MD, MPH; Sharron Docherty, PhD, CPNP (AC/PC)

NQF staff members participating: Reva Winkler, MD, MPH (clinical consultant); Heidi Bossley, MSN, MBA (senior director); Nicole McElveen, MPH (senior project manager); Ashley Morsell, MPH (research analyst).

Measure developers participating: John Bott, MSSW, MBA, and Patrick Romano, MD, MPH, Agency for Healthcare Quality Research (AHRQ).

Welcome, Introductions, and Disclosures of Interest

Ms. McElveen provided an overview of the call, allowed for any disclosures of interest, and welcomed the co-chairs. The Committee had no conflicts of interest to disclose. Co-chairs Dr. Weiss and Dr. Homer thanked everyone for their participation on the call and their preliminary work on evaluating the sub-criteria of the four candidate standards being reviewed on the call.

Project Overview, Work to Date

Dr. Winkler gave a brief synopsis of the NQF Measure Evaluation Criteria. She explained each criterion individually, highlighting what the committee members should be looking for when reviewing candidate standards. She also noted the hierarchy of importance among the criterion, in that the *importance to measure* criterion is a threshold criterion that, if not met, would prevent a candidate standard from moving forward for further evaluation.

Ms. McElveen apprised the Committee of the project's progress thus far and informed them of future expectations and meetings.

Overview Candidate Measures

Ms. McElveen gave a recap of the comprehensive list of submitted standards, acknowledging that there are some the NQF staff have looked at and deemed "out of scope" for the project. She gave the committee the opportunity to examine each individual measure and provide input.

The Steering Committee agreed that the following measures were process measures and therefore out of scope for the Outcomes project:

- OT3-030-10: Antibiotic-impregnated catheter compliance rate;
- OT3-051-10: Pediatric pain assessment, intervention, and reassessment (AIR) cycle (all pediatric patients);
- OT3-052-10: Pediatric pain assessment, intervention, and reassessment (AIR) cycle (pediatric patients in pain); and
- OT3-053-10: Pediatric pain assessment frequency per 24 hours.

Dr. Homer raised a question about measure OT3-050-10: Children who receive standardized developmental and behavioral screening, indicating this measure might also be a process measure and out of scope for this project. NQF staff acknowledged his observation and informed the Committee that the measure is related to several other measures submitted and will be evaluated accordingly at the in-person meeting.

The Committee also was informed that the measures deemed out of scope for the Outcomes project may be considered in upcoming NQF projects.

Consideration of Candidate Measures

Mr. Bott and Dr. Romano introduced the four population-level measures to the committee for review. Mr. Bott explained the rationale behind the methodology used to develop these measures. It was also noted that NQF has endorsed similar measures focused on the adult population. Dr. Romano added that the measures present ambulatory care conditions that are potentially preventable, take a public health view of healthcare, and are designed to raise questions and identify problems within a community or geographical area. The measures are not intended or specified for provider-level measurement. A Steering Committee member also mentioned that these measures are currently in use within several states and communities, such as Massachusetts. Each measure evaluated during the conference call was assigned to committee members to review before the call. The Committee members then led the discussion of the criteria ratings, strengths, and weaknesses.

Before the detailed discussion of the sub-criteria ratings, Dr. Homer indicated that the candidate standards and the constructs on which they are developed have been used widely in various healthcare entities to target disparities in certain populations.

Evaluation of Candidate Measures

OT3-054-10: Urinary tract infection admission rate (pediatric)

Committee members felt this measure should be more explicitly linked to patient outcomes. Committee members emphasized that socioeconomic status and social determinants of health influence hospitalization. While there is the potential for quality improvement with this measure, some Committee members considered usability a concern in that appropriate

healthcare may not always be avoidance of hospitalization. Another issue was the broad inclusion of both upper tract infections that are more serious (pyelonephritis) and lower tract infections (cystitis). Committee members also felt that although UTIs in young children are different than those in adolescents, the measure nevertheless includes children and adolescents aged 3 months to 17 years. Despite that, the data presented is consistent with other types of data available on public reporting of childhood hospitalizations. There is a concern with chart abstraction in that a certain level of reliability on the abstractor to be accurate in data extraction is influential to the results. In addition, the measure developer indicated that reliability testing there hasn't been completed. This measure has been age adjusted and accommodates for the age distribution in different communities. The measure does not address certain variables (health literacy, health education, and problems within the home) associated with children who live in low-income areas and their relation to health outcomes and the rate of hospitalization.

Overall, the reviewers of this measure were *not* favorable to recommending it for endorsement.

OT3-055-10*:* Gastroenteritis admission rate (pediatric)
The Committee noted that this measure addresses a high-frequency illness that is more actionable than the UTI measure. Again, concerns regarding socioeconomic barriers to care and the local availability of primary care and short-stay emergency care for hydration can influence hospitalization. This measure highlights issues of communication, such as when healthcare providers may face cultural or social challenges in educating parents and families about their health. Committee members suggested this measure might evaluate the impact of rotavirus vaccination. A Committee member noted that the only validity testing has been assessment of face validity.

Overall, the reviewers of this measure were favorable to recommend for endorsement.

OT3-056-10: Diabetes, short-term complication rate (pediatric)
Committee members felt that the term "complications" is not clearly defined as the measure is written; it appears that the measure was originally designed for adults with Type 2 diabetes. The Committee thought this measure was more patient focused than the UTI measure, as self-management is a major predisposition for complications. A major concern is the inability to exclude patients who are hospitalized for the initial diagnosis of diabetes. There are no ICD-9-CM codes for new onset diabetes that would differentiate those newly diagnosed patients from those with a preexisting diagnosis who were hospitalized for complications. Committee members also noted that discharges may be coded as "diabetes" without mentioning any complications that occurred. A Committee member recommended modifications to the numerator to include patients who were previously diagnosed with diabetes. The measure developer noted that this measure utilizes cross-sectional hospital discharge data, presenting a challenge to collecting itemized coding information.

OT3-057-10: Asthma admission rate (pediatric)
Steering Committee members noted that hospitalization for asthma are open to inaccuracies during a point-in-time assessment; ED visits would be more sensitive to the quality of ambulatory care for asthma. The measure includes children aged 2-5 years, when the diagnosis is frequently associated with an infectious condition such as pneumonia and is more complex to manage. Committee members suggested that reviewing current data from states such as New York or North Carolina might be informative. A Committee member expressed concern that outcome measurement is difficult and that process measures are easier to use for quality improvement.

Overall, the reviewers of this measure were *not* favorable to recommending it for endorsement

Staff note: From a harmonization perspective, current NQF-endorsed measures for asthma begin at age 5 years.

Next Steps
NQF Staff will circulate another survey later in the week for the Committee members to vote on the measures. Any follow-up discussion, if needed, will occur at the in-person meeting.

Public Comments
No public comments offered.