TO: Consensus Standards Approval Committee (CSAC)

FR: Suzanne Theberge, Senior Project Manager; Nadine Allen, Project Manager; Robyn Nishimi, Senior Consultant

RE: Pediatric Measures Member Voting Results

DA: April 12, 2016

The CSAC will review recommendations from the *Pediatric Measures* project at its April 12 conference call.

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

Member voting on these recommended measures ended on March 29.

Accompanying this memo are the following documents:

1. **Pediatric Measures Draft Report.** The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment table**. Staff has identified themes within the comments received. This table lists 45 comments received and the NQF/Standing Committee responses.

CSAC ACTION REQUIRED

Pursuant to the CDP, the CSAC may consider approval of 15 candidate consensus standards.

Pediatric Measures Recommended for Endorsement:

- 2789: Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care
- 2797: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia
- 2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics
- 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- 2803: Tobacco Use and Help with Quitting Among Adolescents
- 2806: Adolescent Psychosis: Screening for Drugs of Abuse in the Emergency Department
- 2820: Pediatric Computed Tomography Radiation Dose
- 2842: Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator
- 2843: Family Experiences with Coordination of Care (FECC)-3: Care Coordinator Helped to Obtain Community Services
- 2844: Family Experiences with Coordination of Care (FECC)-5: Care Coordinator Asked About Concerns and Health
- 2845: Family Experiences with Coordination of Care (FECC)-7: Care Coordinator Assisted with Specialist Service Referrals

- 2846: Family Experiences with Coordination of Care (FECC)-8: Care Coordinator Was Knowledgeable, Supportive and Advocated for Child's Needs
- 2847: Family Experiences with Coordination of Care (FECC)-9: Appropriate Written Visit Summary Content
- 2849: Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed
- 2850: Family Experiences with Coordination of Care (FECC)-16: Child Has Shared Care Plan

Pediatric Measures Not Recommended

- 2799: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- 2802: Overuse of Imaging for the Evaluation of Children with Post-Traumatic Headache
- 2805: Pediatric Psychosis: Timely Inpatient Psychiatric Consultation
- 2807: Pediatric Danger to Self: Discharge Communication with Outpatient Provider
- 2815: CAPQuaM PQMP Mental Health Follow Up Measure Timeliness 1: Delayed Coordination of Care Following Mental Health Discharge
- 2817: Accurate ADHD Diagnosis
- 2818: ADHD Chronic Care Follow-up
- 2848: Family Experiences with Coordination of Care (FECC)-14: Healthcare Provider Communicated with School Staff About Child's Condition
- 2851: Family Experiences with Coordination of Care (FECC)-17: Child Has Emergency Care Plan

BACKGROUND

A healthy childhood sets the stage for better health and quality of life in adulthood. About 75 million children under 18 years live in the United States, representing 23.3% of the population. Understanding the health-related needs of children is central to selecting appropriate measures to improve quality across the continuum of child healthcare. Currently, more than 100 NQF-endorsed measures encompass the pediatric population (i.e., are pediatric-specific or all-patient). These measures address a broad range of clinical and cross-cutting areas, including cardiovascular surgery, pulmonary care, cancer, perinatal care, health and well-being, and safety. Still, gaps remain in the areas of care coordination (e.g., home- and community-based care, social services coordination, and cross-sector measures that foster accountability in the education system); screening for abuse and neglect; injuries and trauma; and mental health (e.g., access to outpatient and ambulatory mental health services, emergency department use for behavioral health, etc.).

For the first time in several years, NQF undertook a project focused specifically on pediatric measures. Most of the project's measures were Agency for Healthcare Research and Quality (AHRQ)- and the Centers for Medicare & Medicaid Services (CMS)-funded and developed by the Centers of Excellence in Pediatric Quality Measurement (COEs), which aimed to develop new measures or refine existing ones in high-priority areas of pediatric health.

For this project, the 27-member Pediatric Measures Steering Committee evaluated 23 newly-submitted measures and one revised version of a previously reviewed measure against NQF's standard evaluation criteria. During its initial review, the Committee recommended 14 measures, did not recommend 9 measures, and did not reach consensus on 1 measure. Following the comment period, the Committee voted not to recommend the measure for which consensus was not achieved. Additionally, the vote for

1 measure previously not recommended was changed to recommended following developer changes to the specifications. Overall, the Committee recommends 15 measures and does not recommend 9 measures. In addition, 3 measures were withdrawn from consideration prior to the Committee's review and evaluation. Evaluated measures are listed by recommended endorsement status in the draft report.

DRAFT REPORT

The Pediatric Measures Draft Report presents the results of the evaluation of 24 measures considered under the CDP. Fifteen are recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement and nine were not recommended. The measures were evaluated against the 2015 version of the measure evaluation criteria.

	NEW	RESUBMITTED	TOTAL
Measures considered	23	1	24
Withdrawn from consideration	3	0	3
Recommended	14	1	15
Not recommended	9	0	9
Reasons not Recommended	Importance- 4 Scientific Acceptability- 4 Overall- 1 Competing Measure- 0		

COMMENTS AND THEIR DISPOSITION

NQF received 45 comments from 3 member organizations pertaining to the general draft report and to the measures under consideration.

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

Comment Themes and Committee Responses

Comments about the set of Family Experience with Care Coordination (FECC) Measures, lack of access to care, and additional measure-specific issues were forwarded to the developers, who were invited to respond.

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

Theme 1 - Support for Committee Recommendations

Overall, the comments received supported the Committee's recommendations (either for or against endorsement) on the measures. Several comments noted concerns with the measures or provided suggestions for improvement; these are detailed in the section on measure-specific comments.

Theme 2: Family Experiences with Coordination of Care Measures

A commenter submitted similar comments on several of the measures relating to the Family Experiences with Coordination of Care (FECC) measures (2842, 2843, 2844, 2845, 2846, 2847, 2848, 2849, 2850, and 2851). The comments noted, in part, that the measure definition includes ICD-9, and should be expanded to include ICD-10 and SNOMED codes. (The measure relies on the Pediatric Medical Complexity Algorithm [PMCA], which uses ICD-9 codes to classify a child's illness with regard to chronicity and complexity.) The commenter also expressed general concern about the use of ICD codes as the method to determine the denominator population.

While the commenter did note the importance of care coordination and family engagement, it also raised general concerns with the logistics of care coordination. Issues raised included that these measures can only be used in systems where a care coordinator position is available and reimbursed, which requires external support. Additionally, the commenter requested information on how the measure supports the Medical Home when the primary care physician is not part of the network.

A second commenter submitted a single comment supporting all the FECC measures, highlighting the critical importance of measures assessing the quality of coordination of care services from the patient/caregiver's perspective.

The developer's response to the portion of the comments that apply to multiple FECC measures is below and is not repeated for the individual measures. Measure-specific responses are included in the next section with the individual measure.

Developer Response:
NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.

"The measure definition includes ICD-9, which has to be expanded to be relevant to ICD-10 and SNOMEDs."

As described in sections S.9 and 2b.2 of the submission, conversion of PMCA from ICD-9 to ICD-10 codes is underway and should be available later this year. The conversion that has occurred so far is included in the detailed measure specifications attachment. However, because the PMCA uses up to 3 years' worth of retrospective administrative data, the ICD-10 code version is not expected to be needed for widespread use immediately, and would not be appropriate to use until at least 1 full year of ICD-10 codes are available (October 2016).

"This can only happen in systems where a Care Coordinator position is available and reimbursed. This is sustainable only if the practice has support from the health plan or other sources."

While we appreciate the commenter's concern that this might be the case, the survey questions asking about care coordination allow for the "care coordinator" to be anyone, either within or outside of the main provider's office, who "helped [the caregiver] with managing [the] child's care." Specific options on the survey allow the caregiver to identify that person as the main provider, another doctor or nurse, a social worker, or a care coordinator, among other options. The survey is attached to the submission. That language ("the person who helped you with managing your child's care") was the result of cognitive interviews with caregivers of children with medical complexity in English and Spanish, during

which “care coordinator” was not universally understood. The FECC survey measures evaluate the quality of care coordination being provided, regardless of who is providing that care coordination service.

"How does this support the Medical Home where the PCP is not part of the network, but has their own care coordinator?”

As mentioned above, the FECC measures evaluate the quality of care coordination being provided, regardless of who is providing the care coordination services. The measure is structured so that the care coordinator can be part of the medical home or be from outside of the medical home. Thus, if the medical home PCP is providing a care coordinator, those are the services the caregiver will report on – whether or not the medical home is in or out of network.

"We are concerned about using ICD codes as the main way to determine the populations - this is not an accurate reflection of complexity, and compromises the selection of the population."

We appreciate the commenter’s concern that ICD codes might miss some of the nuances of medical complexity, and could mis-classify children. However, there are several reasons that it is not only a reasonable approach, but may be the only feasible approach. To begin with, the FECC measures were designed for use at the state or payment model level, not at the practice level. The eligible population therefore needs to be identifiable on the basis of billing or administrative data, as neither chart review nor practice report would be feasible. In addition, if practice report or registry data were to be used to identify children with medical complexity in need of care coordination, practices could either intentionally or unintentionally report only those who had been flagged by the practice and were already receiving additional care coordination services, thereby improving their performance scores. Such an approach would miss the patients and families who had already fallen through the cracks and were failing to receive needed services. Finally, the PMCA has been validated in both hospital and Medicaid claims data and demonstrated high degrees of sensitivity and specificity for correctly identifying children with medical complexity, compared to a gold-standard population determined via medical record review (see submission section 2b2.2: Validity, and Simon TD et al. “Pediatric Medical Complexity Algorithm: A New Method to Stratify Children by Medical Complexity.” Pediatrics. 133(6), June 2014.)

Committee Response:
Thank you for your comment. After reviewing the comments received, and the developer’s response, the Committee does not wish to reconsider its recommendations on any of the FECC measures.

Theme 3: Lack of Access to Care
A number of the measures rely on access to specialty care, such as psychosocial care (in particular psychiatrists), radiologists, care coordinators, pediatric hospitals, or referrals for abnormal HgbA1C or lipid levels. Commenters noted access to these providers/facilities is not universal and that inability to access these types of care may hinder performance on these measures.

Measure-Specific Comments
NQF received 29 comments that were specific to a measure and that required further response from NQF, the developers, or the Committee. The comments, along with Committee and developer responses, are provided in the comment table.

NQF MEMBER VOTING RESULTS

Six of the recommended measures were approved with 75% approval or higher. Nine of the measures were in the consensus not reached zone (40-60%); one, 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics received 40%, and the rest received 60% approval. Representatives of 18 member organizations voted; no votes were received from the Consumer, Public/Community Health Agency, and Supplier/Industry Councils. Results for each measure are provided below. (Links are provided to the full measure summary evaluation tables.)

Measures where consensus was not reached at NQF Member Vote:

- 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- 2842: Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator
- 2843: Family Experiences with Coordination of Care (FECC)-3: Care Coordinator Helped to Obtain Community Services
- 2844: Family Experiences with Coordination of Care (FECC)-5: Care Coordinator Asked About Concerns and Health
- 2845: Family Experiences with Coordination of Care (FECC)-7: Care Coordinator Assisted with Specialist Service Referrals
- 2846: Family Experiences with Coordination of Care (FECC)-8: Care Coordinator Was Knowledgeable, Supportive and Advocated for Child's Needs
- 2847: Family Experiences with Coordination of Care (FECC)-9: Appropriate Written Visit Summary Content
- 2849: Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed
- 2850: Family Experiences with Coordination of Care (FECC)-16: Child Has Shared Care Plan

NQF Member Council	Voting Organizations	Eligible to Vote	Rate
Consumer	0	37	0%
Health Plan	2	20	10%
Health Professional	6	100	6%
Provider Organizations	4	110	4%
Public/Community Health Agency	0	19	0%
Purchaser	2	20	10%
QMRI	4	80	5%
Supplier/Industry	0	39	0%
All Councils	**18**	**425**	**4%**

Measures Recommended:

Measure # 2789: Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	6	0	0	6	100%
Provider Organizations	3	1	0	4	75%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	0	2	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**15**	**1**	**2**	**18**	**94%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					95%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- Successful transition from pediatric to adult care is critical and therefore we support this measure, however, this measure relies on a patient-reported survey that is administered by mail and the associated sampling and data collection involved may require considerable administrative burden.
- it is an intriguing subject but lacks empirical evidence. As it is a mail-only survey is heavily subject to responder bias. This needs more exploration and should only be adopted for further study.
- We would like to reiterate our previous comments regarding the necessity of making a tool like this compatible with EHRs.

Measure # 2797: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	6	0	0	6	100%
Provider Organizations	4	0	0	4	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	0	2	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**16**	**0**	**2**	**18**	**100%**
Percentage of councils approving (>60%)					100%

Average council percentage approval	100%

*equation: Yes/ (Total - Abstain)

Measure # 2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	3	1	0	4	75%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	4	0	0	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**16**	**2**	**0**	**18**	**89%**
Percentage of councils approving (>60%)					80%
Average council percentage approval					85%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- This measure should report on all children and adolescents 0-17 years of age, rather than reporting age stratifications due to sample size issues. This metabolic screening measure should follow the clinical practice guidelines set forth by the American Diabetes Association and the timing of screenings, both initially and on an ongoing basis, should be evidence-based.
- This should be approved for data gathering purposes only.

Measure # 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	1	1	0	2	50%
QMRI	3	0	1	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**4**	**1**	**18**	**76%**

Percentage of councils approving (>60%)	40%
Average council percentage approval	70%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- Should only be equated to the quality measures for the prescribing physician and not the General Practice Pediatrician seeing the patient afterwards.
- Many patients seek psychosocial care in private practices or community settings for which health plans may not receive claims data. It will be difficult for health plans to capture and document psychosocial care for this measure. Additionally, a bipolar affective disorder (BPAD) diagnosis is listed as an exclusion for this measure. We encourage NCQA to monitor for potential gaming such as increased prescribing resulting from use of exclusionary diagnosis such as BPAD.
- Should be used for data gathering only. The committee's concerns on the lack of accuracy and completeness of the extent of psychosocial care provided are well placed. Should not have been approved for any other purpose than further research.

Measure # 2803: Tobacco Use and Help with Quitting Among Adolescents

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	6	0	0	6	100%
Provider Organizations	4	0	0	4	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	3	0	1	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**17**	**0**	**1**	**18**	**100%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					100%

*equation: Yes/ (Total - Abstain)

Measure # 2806: Adolescent Psychosis: Screening for Drugs of Abuse in the Emergency Department

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	4	2	0	6	67%
Provider Organizations	3	1	0	4	75%
Public/Community	0	0	0	0	

Health Agency					
Purchaser	1	1	0	2	50%
QMRI	2	0	2	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**12**	**4**	**2**	**18**	**75%**
Percentage of councils approving (>60%)					80%
Average council percentage approval					78%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- We approve of the committee's recommendation to endorse the revised measure specifications that now meets the validity criteria.
- Committee's concern that there is a lack of empirical evidence on screening and improved outcome is valid. This really in the realm of public health and epidemiology.

Measure # 2820: Pediatric Computed Tomography Radiation Dose

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	2	0	0	2	100%
Health Professional	6	0	0	6	100%
Provider Organizations	4	0	0	4	100%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	1	1	4	67%
Supplier/Industry	0	0	0	0	
All Councils	**16**	**1**	**1**	**18**	**94%**
Percentage of councils approving (>60%)					100%
Average council percentage approval					93%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- I'm glad to see the change was made to the level of analysis. Health plan is completely inappropriate for radiation dosage.

Measure # 2842: Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator

Measure Council	Yes	No	Abstain	Total Votes	% Approval*

Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	0	2	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**3**	**2**	**18**	**81%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					80%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.
- Lack of data to support implementing this. Needs more work by the committee's own admission.

Measure # 2843: Family Experiences with Coordination of Care (FECC)-3: Care Coordinator Helped to Obtain Community Services

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	3	0	1	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**14**	**3**	**1**	**18**	**82%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					80%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.

Measure # 2844: Family Experiences with Coordination of Care (FECC)-5: Care Coordinator Asked About Concerns and Health

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	1	1	4	67%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**4**	**1**	**18**	**76%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					73%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.
- Sample size too small to make the decision. Needs more work.

Measure # 2845: Family Experiences with Coordination of Care (FECC)-7: Care Coordinator Assisted with Specialist Service Referrals

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community	0	0	0	0	

Health Agency					
Purchaser	2	0	0	2	100%
QMRI	2	0	2	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**3**	**2**	**18**	**81%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					80%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.
- While an interesting investigational subject, as noted the surveys of this type are expensive and time consuming. Should be used for study only not evaluation.

Measure # 2846: Family Experiences with Coordination of Care (FECC)-8: Care Coordinator Was Knowledgeable, Supportive and Advocated for Child's Needs

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	1	1	4	67%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**4**	**1**	**18**	**76%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					73%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination.

Additional measures addressing the same concept will be burdensome to plans to implement.
- See comments on related topics.

Measure # 2847: Family Experiences with Coordination of Care (FECC)-9: Appropriate Written Visit Summary Content

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	2	1	1	4	67%
Supplier/Industry	0	0	0	0	
All Councils	**13**	**4**	**1**	**18**	**76%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					73%

*equation: Yes/ (Total - Abstain)

Voting Comments:
- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.

Measure # 2849: Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	3	0	1	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**14**	**3**	**1**	**18**	**82%**

Percentage of councils approving (>60%)	60%
Average council percentage approval	80%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.

Measure # 2850: Family Experiences with Coordination of Care (FECC)-16: Child Has Shared Care Plan

Measure Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	0	0	0	
Health Plan	1	1	0	2	50%
Health Professional	6	0	0	6	100%
Provider Organizations	2	2	0	4	50%
Public/Community Health Agency	0	0	0	0	
Purchaser	2	0	0	2	100%
QMRI	3	0	1	4	100%
Supplier/Industry	0	0	0	0	
All Councils	**14**	**3**	**1**	**18**	**82%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					80%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- The expectation that all providers will have the resources or availability of a dedicated care coordinator is unrealistic.
- Existing surveys such as Health Plan CAHPS measure care coordination. Additional measures addressing the same concept will be burdensome to plans to implement.

Appendix A-Measure Evaluation Summary Tables

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

2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia
Submission | Specifications
Description: The percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year. Numerator Statement: The numerator is the number of children ages 2 through 15 years old with sickle cell anemia who received at least one TCD screening within the measurement year. Denominator Statement: The denominator is the number of children ages 2 through 15 years with sickle cell anemia within the measurement year. Exclusions: There are no denominator exclusions. Adjustment/Stratification: Level of Analysis: Health Plan Setting of Care: Other Type of Measure: Process Data Source: Administrative claims Measure Steward: Q-METRIC – University of Michigan
STEERING COMMITTEE MEETING [12/01/2015-12/02/2015] 1. Importance to Measure and Report: **The measure meets the Importance criterion** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-18; M-8; L-1; I-0**; 1b. Performance Gap: **H-23; M-4; L-0; I-0** Rationale: • The developer stated evidence for this process measure is based on clinical practice guidelines for management of sickle cell disease from the National Heart, Lung, and Blood Institute (NHLBI). Dated 2014, this is a strong recommendation with moderate quality evidence. The recommendation is: "In children with SCA, screen annually with TCD according to methods employed in the STOP studies, beginning at age 2 and continuing until at least age 16." • The Committee concurred the measure aligned with the NHLBI guidelines for annual transcranial doppler (TCD) screening of children with sickle cell anemia; TCD ultrasonography is the only method available to identify those who are at high risk for a stroke. • The Committee agreed the clinical evidence provided by the measure developer demonstrated that lack of annual screening is strongly associated with poor outcome. • The Committee expressed concern about the availability and quality of TCD screening across different health centers around the country, including access to a health workforce with the proper expertise in performing the screening. The Committee agreed, however, such concerns should not preclude this measure from moving forward. • The measure developer confirmed the measure recommends one TCD screening annually, from ages 2 to 16 years old. • Committee members highlighted performance gaps between different types of health plans (e.g., Medicaid versus commercial). The measure was primarily tested in the Medicaid population, and the Committee suggested testing in the commercial insurance population to ensure the measure would yield the same results. A Committee member noted most patients with sickle cell disease qualify for Medicaid after a relatively short time period, and the measure developer confirmed at least 70% of children with sickle cell anemia are enrolled in Medicaid.

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- Based on data presented from different states, Committee members concurred a gap in care exists, and there is an opportunity for improvement. They also noted disparities based on socioeconomic status are unlikely, since the majority of the children with sickle cell disease are covered by Medicaid.

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-17**; **M-9**; **L-0**; **I-0** 2b. Validity: **H-20**; **M-6**; **L-0**; **I-0**

Rationale:

- The Committee expressed concern about the process of identifying children with sickle cell disease and noted the measure should include stringent diagnosis specifications for identifying the condition. The Committee ultimately agreed the developer demonstrated that patients with sickle cell disease could be reliably identified.
- The measure developer conducted signal-to-noise testing at the performance measure level.
- Empirical validity testing was performed at both the critical data element and the performance measure score levels. Face validity also was established by a panel of national experts and parent advocates, as well as measurement and state Medicaid experts. The Committee did not identify any threats to validity.
- The Committee agreed this measure met the Reliability and Validity criteria.

3. **Feasibility: H-24; M-2; L-0; I-0**

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

Rationale:

- This measure is a health plan level measure collected through administrative claims data. The Committee agreed this should be easy to collect and had no feasibility concerns.

4. Usability and Use: **H-22; M-4; L-0; I-0**

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

Rationale:

- The measure is currently in use for surveillance purposes by the New York State Health Department.
- The Committee agreed the measure met the Usability and Use criterion.

5. Related and Competing Measures

- There are no related or competing measures noted.

Steering Committee Recommendation for Endorsement: Y-26; N-0

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- This measure received three comments from three separate organizations. The first commenter noted the importance of yearly screening as a first step, but raised several questions about the measure overall (e.g., interventions and patient refusals) as well as the numerator and denominator details. The second comment noted this measure is at the health plan level and stated the measure could be improved by supporting mechanisms at the primary care level for tracking, such as coding at the electronic health record (EHR) level. The third comment supported the Committee's recommendation for endorsement.

Developer response:

- General Comment:
  We agree that receipt of intervention in the form of transfusions or hydroxyurea is the causal step in preventing stroke among children with sickle cell anemia. However, that intervention should not be initiated without the use of TCD screening to identify candidates for intervention. Therefore, the use of TCD screening is recommended by the National Heart, Lung, and Blood Institute (NHLBI) for all children

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with sickle cell anemia from 2-16 years of age. Consequently, measures reflecting appropriate use of TCD screening are an important indicator of quality of care among children with sickle cell disease. However, the proposed measure is specified and tested to identify children with sickle cell anemia and their receipt of TCD screening solely based upon administrative claims data. Complete information on transfusions and hydroxyurea interventions will require additional data from clinical information sources. Future enhancement of this measure as an e-measure may provide an opportunity to measure quality of care related to these interventions. Finally, although parents may refuse screening on religious grounds or for other personal reasons, we do not expect this refusal to vary by health plan. • Numerator Details: Our numerator is reflective of NHLBI guidelines, which state that each child with sickle cell anemia should receive an annual TCD screen from ages 2-16. All CPT codes reflective of a TCD screen will be captured, irrespective of place of service or provider. Therefore, any screens performed by an MD, RN, or other health professional will be included in this measure. • Denominator Details: Three separate encounters related to sickle cell anemia identify children with a high level of sensitivity (91.4%) and specificity (80.0%) when compared to the gold standard of newborn screening records (please see NQF Testing documentation). Each sickle cell anemia-related encounter is not limited by location or provider—therefore, does not need to occur at the same center where the screening is performed. Additionally, receipt of TCD screening may occur at any location and is not limited to the hematology medical home; therefore, this location is not specified within this measure. • Response to other comment: We agree LOINC and SNOMED coding systems would be important for capturing orders and results pertaining to transcranial Doppler (TCD) screening at the primary care level. However, this measure was specified and tested to identify children with sickle cell anemia and their receipt of TCD screening solely based upon administrative claims data. The specification of LOINC and SNOMED codes would be appropriate for future enhancement of this measure, such as for e-measures based on clinical information systems. Committee response: • Thank you for your comment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2789 Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care

Submission | Specifications

Description: The Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care measures the quality of preparation for transition from pediatric-focused to adult-focused health care as reported in a survey completed by youth ages 16-17 years old with a chronic health condition. The ADAPT survey generates measures for each of the 3 domains: 1) Counseling on Transition Self-Management, 2) Counseling on Prescription Medication, and 3) Transfer Planning.

Numerator Statement: The ADAPT survey consists of 26 questions assessing the quality of health care transition preparation for youth with chronic health conditions, based on youth report of whether specific recommended processes of care were received. The ADAPT survey generates measures for each of 3 domains: 1) Counseling on Transition Self-Management, 2) Counseling on Prescription Medication, and 3) Transfer Planning. ADAPT measure scores are calculated using the sum of the proportions of positive responses to between 3 and 5 individual items. Complete instructions for measure score calculations are provided in the Detailed Measure Specifications (Appendix A).

1) Counseling on Transition Self-Management:

The numerator is the sum of the proportions of positive responses to the five questions about counseling on transition self-management, among respondents with valid responses to all questions.

2) Counseling on prescription medication:

The numerator is the sum of the proportions of positive responses to the three questions about counseling on prescription medication, among respondents who indicate that they take prescription medication every day and with valid responses to all questions.

3) Transfer planning:

The numerator is the sum of the proportions of positive responses to the four questions about transfer planning, among respondents who report being treated by a pediatric provider and with valid responses to all questions.

Denominator Statement: The target population of the survey is 16- or 17-year-old adolescents with a chronic health condition who are either (a) receiving health care services in a clinical program or (b) enrolled in a health plan or similar defined population.

The denominator for each measure is the number of respondents with valid responses for all of the questions in the measure.

Exclusions: SURVEY SAMPLE

Exclude patients in the following categories from the ADAPT survey sample frame:

1. “No-publicity” patients (i.e., those who requested that they not be contacted)

2. Court/law enforcement patients

3. Patients with a foreign home address

4. Patients who cannot be surveyed because of local, state, or federal regulations

SURVEY RESPONSE

Exclude survey respondents based on the following clinical and non-clinical criteria:

1. Undeliverable survey, i.e., the survey is returned by US Mail as undeliverable. “Undeliverable” should not be assumed merely because of non-response.

2. The survey is returned with clear indication that the patient does not meet eligibility criteria (e.g., ineligible age or lack of a chronic health condition).

3. Patient unable to complete survey independently: This must be indicated by the appropriate checkbox in the cover letter or equivalent clear indication by the parent/guardian that the patient is unable to complete the survey independently (e.g., due to cognitive limitation).

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4. Exclude all respondents who answered "None" to ADAPT question 3 ("In the last 12 months, how many times did you visit this provider?").

Adjustment/Stratification:

Level of Analysis: Facility, Clinician : Group/Practice, Health Plan

Setting of Care: Ambulatory Care : Clinician Office/Clinic

Type of Measure: PRO

Data Source: Patient Reported Data/Survey

Measure Steward: Center of Excellence for Pediatric Quality Measurement

STEERING COMMITTEE MEETING [12/01/2015-12/02/2015]

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

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

1a. Evidence: **Y-22; N-2**; 1b. Performance Gap: H-2; M-16; L-5; I-1

Rationale:

- This is a patient-reported outcome measure with 3 domains included in a single measure: 1) Counseling on Transition Self-Management, 2) Counseling on Prescription Medication, and 3) Transfer Planning.
- The Committee agreed transitions from pediatric to adult care are an area of care that needs improvement, and that these conversations should be happening by age 16. A Committee member also noted this is a major transition for these patients, and it should be introduced by the primary healthcare provider.
- The Committee discussed the age range specified by the measure, since these transitions may be happening later due to changes in health insurance regulations. It ultimately agreed the range was appropriate.
- Limited evidence exists that physician counseling will achieve transition readiness. In addition, the Committee noted some groups, such as children with developmental disabilities, may have a high need for transition services, but may not be able to participate in this type of transition planning (or participate in this survey).
- Because this is a patient-reported outcome measure, the developer was required to demonstrate the target population values the measure and finds it useful. The developer provided data on focus groups that demonstrated the target populations (adolescents 16-18 and young adults 19-26, with chronic health conditions) do value the measure. The Committee noted this measure is novel because it asks adolescents for their assessment, not their parents/caregivers.
- Despite finding the measure conceptually compelling, and noting there is evidence that care transitions are not being done well, the Committee had some concerns that the processes focused on in the domains linked to actual improved outcomes. However, it ultimately passed the Evidence criteria.
- Concerns also were expressed about whether there was a performance gap. The developer stated the data from field testing demonstrated a population-level gap, with scores on all 3 domains low, especially for the transition planning domain.

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 (all three domains): H-0; M-18; L-5; I-1

2b. Counseling on Transition Self-Management domain and Counseling on Prescription Medication domain Validity: H-1; M-20; L-2; I-1

Transfer Planning domain Validity: **H-0; M-15; L-6; I-3**

Rationale:

- This measure was tested at the critical data element level and the performance measure score level, but

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data only were provided at the performance measure score level.

- The measure was tested in 1 hospital and 2 health plans serving Medicaid enrollees; the sites were geographically dispersed.
- The response rate by setting varied from 21% and 28% for the health plans and 47% for the clinical programs. The initial deployment for the health plans was 1,500 surveys and 623 for the clinical programs. The Committee noted concerns about the low response rate, particularly at the health plan level.
- Internal consistency reliability tested with ordinal alpha was provided for each of the 3 domains at each of the 3 test sites. Results ranged from 0.74-0.99, with 1 exception at 1 site (0.57). These results generally indicate good to excellent reliability. The transfer planning measure had the highest score—0.99 at each site. Counseling on transition ranged from 0.70 to 0.79. The alphas for counseling on prescriptions were 0.57, 0.74, and 0.78.
- Empirical validity testing at the performance measure score level was performed.
- Because this is a PRO, focus groups and cognitive interviews were conducted to test content validity and to confirm each question was understandable.
- Confirmatory factor analysis for the 2 counseling measures was performed; it could not be performed for the transfer planning measure due to small sample size. Because of this, the Committee elected to split its votes on validity; the transfer planning domain was voted on separately from the 2 counseling domains.
- The Committee questioned the exclusion of individuals who are not capable of completing the survey independently (due to cognitive limitations, etc.); a Committee member noted these individuals might be the patients most in need of this type of service. The developer agreed adolescents with developmental and intellectual delays need transition planning, but stated patients who cannot complete the survey had to be excluded since it is a patient-reported survey. (If a parent or caregiver completed the survey, the developer excluded it from analysis.) The developer further indicated this measure was intended for the general population, and other measures should be developed for targeted populations.
- The developer reported risk adjustment/case mix for self-reported health status and age.
- The developer assessed variation by education and gender; no variation was found so these were not included in the final risk adjustment model. The developer stated it did not have enough variability for race/ethnicity to include it in a testing model. The developer reported it found variation based on medical complexity and the patient's county of residence. Committee members noted potential other variables that could be used for risk adjustment, such as language; the developer explained it had chosen variables that were readily available from the survey instrument and further noted they were limited by the data they had available.

3. Feasibility: H-1; M-19; L-4; 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:

- The ADAPT survey is administered by mail. The developer's rationale for not using electronic sources (e.g., web-based or e-mail administration) is that mail and telephone administration are the best ways to obtain representative samples of patients based on the contact information (mailing address and telephone number) most often available for sampling and data collection. However, the Committee identified concerns with the approach and rationale, noting for adolescents in particular, an electronic survey would be more appropriate. The developer stated it is looking into electronic survey administration.
- The Committee noted the survey is short, so it should be easy to use, but the developer did not address the feasibility of identifying the eligible denominator pool.

4. Usability and Use: H-3; M-16; L-2; I-2

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

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Quality Improvement) Rationale: • The measure is not currently in use, and the developer did not present a specific plan for use, but noted many groups have inquired about using the tool since it became available in the last six months.
5. Related and Competing Measures • This measure is related to 0005: CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child. It is not completely harmonized. The developer indicates CG-CAHPS is intended to be completed by parents and ADAPT is intended to be completed by adolescents. The developer stated, "the ADAPT survey complements the CG CAHPS survey well and has the potential to be administered concurrently."
Steering Committee Recommendation for Endorsement: Y-16; N-7
6. Public and Member Comment: January 14, 2016 - February 12, 2016 Comments received: • This measure received two comments of support. Both comments noted it is an important topic area, but one also added there is room for improvement, such as ensuring there are tools that are compatible with current EHRs; the development of a follow-up outcome measure; and future use of system-wide EHRs. In addition, the comment requested more information on how the measure could be used for children with intellectual disabilities or severe learning disabilities. Developer response: • We thank the AAP for their comments and are glad that they view ADAPT as an excellent tool for addressing transition. ADAPT is focused on pre-transition preparation and we agree that post-transition measurement is important. We agree that system-wide EHRs would allow for improvements in the transition process, and we concur that standard tools to assess transition preparation for adolescents should be incorporated into existing EHR systems. We agree that transition preparation is important for adolescents with intellectual and developmental disabilities. The domains of the ADAPT measure clearly apply to this population as well. However, the ADAPT survey is designed for adolescents without such conditions, and measure testing was not performed in cognitively impaired populations. For these adolescents, a measure tailored to their cognitive abilities would need to be developed; potentially a proxy-reported measure would be appropriate for this patient population. Committee response: • Thank you for your comment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
Submission | Specifications
Description: The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Numerator Statement: Children and adolescents who received glucose and cholesterol tests during the measurement year.

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Denominator Statement: Children and adolescents who had ongoing use of antipsychotic medication (at least two prescriptions).

Exclusions: No exclusions

Adjustment/Stratification:

Level of Analysis: Health Plan, Integrated Delivery System, Population : State

Setting of Care: Ambulatory Care : Clinician Office/Clinic, Laboratory, Behavioral Health/Psychiatric : Outpatient

Type of Measure: Process

Data Source: Administrative claims

Measure Steward: National Committee on Quality Assurance

STEERING COMMITTEE MEETING [12/01/2015-12/02/2015]

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

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

1a. Evidence: H-4; M-18; L-0; I-1; 1b. Performance Gap: H-10; M-13; L-0; I-0

Rationale:

- The developer provided the following relationship between the process being measured and outcome: Child or adolescent has ongoing use of antipsychotic medication >>> Metabolic monitoring by a health care provider >>> Identification of metabolic issues/side effects >>> Health care provider addresses metabolic issue by, for example, adjusting antipsychotic medication regimen >>> Patient receives intervention for metabolic issues present >>> Metabolic issues reduced or eliminated >>> Improvement in metabolic functioning for patient (desired outcome).
- Overall, the Committee agreed this is an important measure to monitor the serious side effects of prescribing antipsychotic medications to children and adolescents (e.g., diabetes, rapid weight gain).
- The measure is based on 11 evidence-based clinical practice guidelines and standards from 5 organizations, particularly the guidelines from the American Academy of Child and Adolescent Psychiatry (AACAP).
- The Committee agreed evidence exists to support metabolic monitoring, specifically glucose monitoring and lipid monitoring for children on antipsychotics. Clear recommendations are provided by the professional societies regarding concern for metabolic derangements.
- The Committee sought clarification on timing, which the developer defines as 2 prescriptions of the same drugs or 2 different drugs during the measurement year.
- During field testing, the developer found the percentage of children receiving metabolic screening within 30 days of a new antipsychotic medication prescription was 6.0%, with a range of 0.4% to 14.0%. For children and adolescents who had ongoing antipsychotic use, the percentage who received metabolic monitoring was on average 18.5%, with a range of 4.8% to 36.2%. In an examination of claims data from 17 Medicaid health plans in 1 state, the developer found the average percentage of children receiving baseline metabolic screening within 30 days of a new antipsychotic medication prescription among the general population of children in health plans was 10.3%, with a range of 0.2% to 17.8%. For ongoing metabolic monitoring during the measurement year, the data suggest similar gaps in care. The percentage of children with ongoing antipsychotic use receiving metabolic monitoring during the measurement year was 30.9%, with a range of 2.3% to 40.0%. The Committee noted the low rate of performance and the broad range, indicating there is a performance gap.

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-5; M-18; L-0; I-0 2b. Validity: H-5; M-18; L-1; I-0

Rationale:

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- The Committee determined the measure specifications were precise, noting the specifications were consistent with the evidence presented.
- Reliability testing was performed at the performance measure score level using a beta-binomial signal-to-noise analysis. The average reliability for states and plans was > 0.7 (ranging from 0.99 to 0.83), suggesting the measure is reliable, particularly at the Medicaid health plans and state levels.
- Validity testing included construct validity (i.e., correlations among measures and rankings of health plans and states on measures on the three antipsychotic medication measures) and consensus validity by 5 expert panels. Among national commercial plans, there was a very slight positive correlation between the First-line Psychosocial Care and Metabolic Monitoring measures (r=0.12, p=.70) and high positive correlation between the Metabolic Screening and Metabolic Monitoring measures (r=0.82, p<0.0001). Among Medicaid plans in one state, there was a slight positive correlation between the Follow-up Visit and Metabolic Monitoring measures (r=0.14, p=.58) and high positive correlation between the Metabolic Screening and Metabolic Monitoring measures (r=0.72, p<0.001).
- The Committee voiced no concerns about the reliability and validity testing.

3. Feasibility: H-15; M-9; L-0; I-0

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

Rationale:

- The Committee noted the measure is feasible for collection by health plans and states using administrative claims data.

4. **Usability and Use**: H-10; M-14; L-0; I-0

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

Rationale:

- The Committee had no questions or concerns on the usability and use of this measure.

5. Related and Competing Measures

- This measure directly relates to two other measures, #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) and #2337: Antipsychotic Use in Children Under 5 Years Old. This measure has a different target population and focus.

Steering Committee Recommendation for Endorsement: Y-24; N-0

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- This measure received comments from two organizations. One comment noted a number of potential areas for improvement, including supportive mechanisms for tracking at the primary care or patient EHR level; suggested exclusions and implementation protocols; and the development of an accompanying measure to ensure appropriate follow-up and record keeping. The comment also flagged concerns about the availability of referral for abnormal results; lack of clarity around the criteria for changing or stopping medications; and "the medicolegal consequences for failure to meet this quality measure may be forthcoming." The other comment supported the Committee's recommendation for endorsement.

Developer response:

- The value set to identify the glucose and cholesterol lab tests for this measure does include both CPT and LOINC codes. Because this measure is specified at the health plan level, it accounts for care that is provided across different providers and care settings. This is particularly important for assessing care for children and adolescents prescribed antipsychotics who may be seeing both a primary care provider as well as a mental health specialist. The measure will encourage appropriate metabolic monitoring for

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youth on antipsychotics regardless of which providers they see. • This measure is based on guidelines from the American Academy of Child and Adolescent Psychiatry (AACAP), Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMESA), and others. These organizations recommend metabolic testing for youth prescribed antipsychotics, with consensus that baseline and ongoing metabolic monitoring are standards of care for this population. The AACAP and CAMESA guidelines include recommendations for the timing of these tests. AACAP recommends that glucose and cholesterol tests should be monitored at baseline, 3 months and 12 months. CAMESA recommends monitoring at baseline, three months, 6 months and 12 months. We found from testing that only about 30 percent of children and adolescents on antipsychotics received lab monitoring once during the year, suggesting a significant quality gap. Thus, we specified the measure as receiving lab monitoring within the measurement year in order to address the quality gap while balancing the burden of assessing exact timing of visits. • This measure applies to states and health plans. Our advisory panels did not recommend a "refusal" exclusion, which is not appropriate at a state- and health-plan measure level. We would expect that the number of children meeting these criteria would be fairly small and relatively evenly distributed at the state- and health-plan level. Further, this measure uses administrative claims for data collection. Therefore it would be challenging and potentially burdensome to have an exclusion for children and adolescents who refuse a blood draw or are otherwise "uncooperative". Committee response: • Thank you for your comment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Submission | Specifications
Description: Percentage of children and adolescents 1-17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment. Numerator Statement: Children and adolescents from the denominator who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic. Denominator Statement: Children and adolescents who had a new prescription of an antipsychotic medication for which they do not have a U.S Food and Drug Administration primary indication. Exclusions: Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration indication and are thus clinically appropriate: schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders. Adjustment/Stratification: Level of Analysis: Health Plan, Integrated Delivery System, Population : State Setting of Care: Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Inpatient, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Administrative claims Measure Steward: National Committee on Quality Assurance
STEERING COMMITTEE MEETING [12/01/2015-12/02/2015]

2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

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

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

1a. Evidence: H-0; M-7; L-4; I-13; Insufficient Evidence with Exception: Y-21; **N-3;** 1b. Performance Gap: H-5; M-16; L-2; I-0

Rationale:

- This measure encourages the use of psychosocial care prior to or immediately following administration of antipsychotics if the child does not have a U.S. Food and Drug Administration (FDA) indication for antipsychotics (schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders). If psychosocial care is successful, antipsychotic use may be halted or avoided altogether. The developer provided the following path: Child does NOT have a primary indication for antipsychotic use >>> Health care provider utilizes psychosocial care intervention >>> Child avoids unnecessary antipsychotic use >>> Child avoids adverse side effects associated with antipsychotic medications >>> Child experiences improvement in mental and physical outcomes (desired outcome).
- The measure is based on 11 evidence-based clinical practice guidelines and standards from five organizations, particularly the guidelines from the American Academy of Child and Adolescent Psychiatry (AACAP).
- The Committee agreed on the importance of measuring the use of first-line psychosocial therapy for children and adolescents on antipsychotics, but it noted the evidence is largely consensus-based. It was particularly concerned about the times where it is appropriate to initiate pharmacotherapy without waiting for psychosocial interventions. Due to the lack of empirical evidence, this measure did not pass Evidence, but moved forward on Insufficient Evidence with Exception given the importance of the measure focus.

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-4; M-18; L-2; I-0 2b. Validity: H-0; M-13; L-7; I-4

Rationale:

- Reliability testing was performed at the performance measures score level using a beta-binomial signal-to-noise analysis. The average reliability at the state level was 0.99, the Medicaid plan level was 0.97, and the commercial plan level was 0.77, suggesting a very high level of reliability for the measure, particularly for states and Medicaid plans.
- The Committee expressed reservations about the validity of the specifications. It felt the prescription data could be readily captured, but expressed concern about the ability to accurately capture the psychosocial care, since many children may receive psychosocial care outside of the measured entity of the health plan (e.g., schools and community health centers). As an example, it was noted many health plans do not cover some types of psychosocial care. The prescription data might be captured, but the first-line psychosocial care might not be if it was provided, but not covered. Committee members noted this was true for both commercial and Medicaid plans, with the further complication of state variation in coverage among Medicaid plans.
- The Committee also questioned whether recommending therapy first, before medications, would improve quality of care, especially since access to therapy services might not be available for several months—i.e. whether the risk of not treating could worsen the quality of care. The Committee stated the role of early intervention services—either medication in conjunction with therapy or and therapy in conjunction with medication—is not addressed by this measure.
- Validity testing was at the performance measure score level using both empirical testing and face validity at the plan level. For the empirical testing, the developer assessed construct validity with two types of analyses: correlations among measures using Spearman Correlation Coefficients (using a commercial health plan data sample) and rankings of health plans and states on measures (using MAX state data

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sample and Medicaid health plan data sample). • The Committee noted that for validity testing it would have appreciated more claims-based information that actually reflected details about the histories for these children. The developer noted it did consider including more charts, however experienced significant barriers in access to all of the records needed that could have answered the Committee's question. • The Committee did not reach consensus on the Validity criterion for #2801, but the measure passed the other NQF criteria and it passed Overall Suitability for Endorsement.
3. Feasibility: H-6; M-12; L-5; I-1 (3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented) Rationale: • The Committee noted the limitations of the data source. Since the measure relies on administrative claims data, it may be difficult for health plans to collect supplemental data due to the complication of state variation in benefits coverage among Medicaid plans.
4. **Usability and Use**: H-4; M-13; L-6; I-1 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The Committee had no questions or concerns on the usability and use of this measure.
5. Related and Competing Measures • This measure directly relates to the NQF-endorsed 2337: Antipsychotic Use in Children Under 5 Years Old. However, this new measure has a broader age population and different focus (i.e., focus on new diagnosis and use of psychosocial care).
Steering Committee Recommendation for Endorsement: Y-17; N-7
6. Public and Member Comment: January 14, 2016 - February 12, 2016 Comments received: • This measure received comments from two organizations. One comment noted it is important issue, but agreeing with the significant concerns raised by the Committee. It also noted the lack of uniform availability of psychosocial care, and requested the addition of children with autism. A second comment supported the Committee's recommendation for endorsement. Developer response: • We agree with the importance of this measure and the need for access to first-line psychosocial care for children and adolescents who are started on antipsychotics without a primary indication. This state- and health plan-level measure requires that the plan have a mental health benefit. This is to ensure that health plan members would have access to mental health and psychosocial services through their health plan benefit. In recognition that availability of mental health providers is an issue in some markets, the measure allows for psychosocial care delivered up to 30 days after an antipsychotic is started. We also agree with the commenter that children with autism should in general be provided psychosocial care. Since autism is a condition for which there is a Food and Drug Administration (FDA) indication for first-line antipsychotic use, we exclude these individuals from the measure. This is not to say that providing psychosocial care would not be important or appropriate for those with autism, but rather the exclusion of individuals with an FDA indication for antipsychotics focuses the measure on those for whom clinical guidelines recommend first-line psychosocial care before starting on antipsychotics. Committee response: • Thank you for your comment.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2803 Tobacco Use and Help with Quitting Among Adolescents
Submission | Specifications
Description: Percentage of adolescents 12 to 20 years of age during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user. Numerator Statement: Adolescents who are not smokers OR Adolescents who are smokers but are receiving cessation counseling. Denominator Statement: Adolescents who turn 12 through 20 years of age during the measurement year. Exclusions: N/A Adjustment/Stratification: Level of Analysis: Clinician : Group/Practice Setting of Care: Ambulatory Care : Clinician Office/Clinic Type of Measure: Process Data Source: Electronic Clinical Data Measure Steward: National Committee for Quality Assurance
STEERING COMMITTEE MEETING [12/01/2015-12/02/2015] 1. Importance to Measure and Report: **The measure meets the Importance criterion** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: **H-11**; **M-12**; **L-0**; **I-1** 1b. Performance Gap: **H-12**; **M-11**; **L-0**; **I-1** Rationale: • The measure aims to standardize the way tobacco use is documented. • The evidence supporting measure #2803 is based on 2 clinical practice guidelines from the U.S. Preventive Services Health Task Force (USPSTF) and the American Academy of Pediatrics (AAP); both derive their evidence from a systematic review of the evidence. • Data submitted by the developer noted evidence has shown a physician's advice on tobacco cessation can be effective. • The Committee acknowledged cessation counseling is a proven and effective practice, but expressed concerns over the quality of counseling assessment. • The Committee asked the measure developer to clarify the measure details, and received confirmation that "physician advice" encompasses counseling, referral to services, treatment services, and medication, and is aligned with other counseling measures included in HEDIS, as well as an adult version of this measure. • The Committee discussed concerns about the possibility of data manipulation based on information entered automatically on each patient's after-visit summary. The developer clarified this is in the interest of counting a broad array of interventions that could apply. • Data provided by the measure developer showed an opportunity for improvement, especially between commercial and Medicaid health plans populations (82% vs. 60%).
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criterion

2803 Tobacco Use and Help with Quitting Among Adolescents

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

2a. Reliability: **H-0**; **M-20**; **L-4**; **I-0** 2b. Validity: **H-2**; **M-19**; **L-2**; **I-1**

Rationale:

- The Committee asked for clarification on the numerator specifications, and the measure developer confirmed the measure is specified for all tobacco use and is not limited to cigarette smoking. The use of e-cigarettes is not specifically included in the specifications because they were not as popular a few years ago when the measure was developed. The Committee encouraged the developer to examine including e-cigarettes in future iterations.
- The developer conducted empirical testing at 3 pediatric centers. Reliability testing was done at the level of data elements using a sub-sample of 75 adolescents from the initial sample of 597.
- Committee members suggested the developer clearly specify the types of counseling being given to ensure clinicians are not merely checking-off documentation. The measure developer confirmed it has aligned this measure with other counseling measures in HEDIS to include referral, treatment, and medication services in addition to counseling.
- The Committee agreed the measure met the Reliability and Validity criteria.

3. **Feasibility: H-1; M-19; L-4; 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 for this measure needs to be manually abstracted from a healthcare provider's record.
- Some components of this measure are aligned with the Meaningful Use definition of tobacco use status.
- The measure has been specified as an eMeasure, but is not being submitted as an eMeasure at this time.
- The Committee had an in-depth discussion on the measure's susceptibility to inaccuracies based on chart reviews and diagnosis codes on electronic charts. The Committee suggested documentation should involve detailed questionnaires and specific summary instructions to ascertain clinicians are actually reviewing information with the adolescents and their families. The Committee concurred this concern should not preclude this measure from moving forward.
- This measure is aligned with an existing tobacco use measure for adults, with the exception of nicotine patch prescriptions, which are not appropriate for adolescents. Having the same measure construct allows this measure to be easily implemented because large organizations already have experience with the adult population and can mirror the same steps for this pediatric/adolescent measure.

4. **Usability and Use: H-5; M-16; L-3; I-0**

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

Rationale:

- The measure is currently in use in PRQS for 2015 and the EHR Incentive Program (Meaningful Use).
- The Committee raised concerns about Usability and Use.

5. Related and Competing Measures

- This measure, #2803, is related to 1 NQF-endorsed measure, NQF 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention.
- NQF 0028 has a different target population (18 years and older), while this measure covers ages 12 years to 20 years.

Steering Committee Recommendation for Endorsement: Y-21; N-3

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

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• This measure received comments from two organizations. One comment noted it is an important gap area for adolescent health, but that the measure is duplicative of currently endorsed measures. The commenter noted the existing measure should be expanded instead. It also raised concerns with the exclusion of e-cigarettes and nicotine patches, and requested clarity on the algorithm. A second organization supported the Committee's recommendation for endorsement. Developer response: • The measure specifies adolescents, a different patient population than the adult measure that is currently in use. The measure aligns to the adult tobacco use measure specifications and also aligns with Meaningful Use tobacco definitions. We agree that this measure addresses an important area for adolescent health. We are exploring whether e-cigarettes should be included in the measure, as the evidence around this form of tobacco use is emerging. In step 2 of the calculation algorithm we would like to clarify that 2a and 2b together identify the numerator and that the numerator is not solely "tobacco users." While we recognize the AAP's clinical practice policy states NRT can be used in adolescents, our current approach is to follow Food and Drug Administration guidance. Our team can assess the AAP policy further in the future. Committee response: • The Committee discussed this comment on the post-comment call and agreed that, despite the limitations of the measure, it covers an important topic area and should be recommended for endorsement. The Committee recommends improvements, such as including e-cigarettes, in future versions.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2806 Adolescent Psychosis: Screening for Drugs of Abuse in the Emergency Department
Submission | Specifications
Description: Percentage of children/adolescents age =12 to =19 years-old seen in the emergency department with psychotic symptoms who are screened for alcohol or drugs of abuse Numerator Statement: Eligible patients with documentation of drug and alcohol screening using urine drug or serum alcohol tests. Denominator Statement: Patients aged =12 to =19 years-old seen in the emergency department with psychotic symptoms. Exclusions: No patients were excluded from the target population. Adjustment/Stratification: Level of Analysis: Facility Setting of Care: Emergency Medical Services/Ambulance, Hospital/Acute Care Facility Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records Measure Steward: Seattle Children's Research Institute
STEERING COMMITTEE MEETING [12/01/2015-12/02/2015] 1. Importance to Measure and Report: **The measure meets the Importance criterion** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: H-0; M-2; L-3; I-19; Insufficient Evidence with Exception: Y-16; N-8; 1b. Performance Gap: H-2; M-18;

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L-3; I-1

Rationale:

- The developer cited a 2013 guideline from the American Academy of Child and Adolescent Psychiatry (AACAP): "Clinical Practice Guideline Recommendation 3. Youth with suspected schizophrenia should be carefully evaluated for other pertinent clinical conditions and/or associated problems, including suicidality, comorbid disorders, substance abuse, developmental disabilities, psychosocial stressors, and medical problems." The developer provided no additional reviews or literature, and indicated no studies were identified since AACAP published the guideline in 2013.
- The Committee noted the lack of strong empirical evidence that screening has an impact on improved outcome, however, agreed this measure qualified for consideration under Insufficient Evidence with Exception.
- Performance gap information was derived from testing the measure using data aggregated during a 2-year period from 3 children's hospitals and 2 community hospitals. The performance scores ranged from 17.8% to 83.3%.
- The Committee agreed a gap existed, as represented by the wide range of performance by the emergency departments (EDs) at different types of hospitals.

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-1; M-13; L-9; I-1 2b. Validity: H-0; M-17 ; L-4 ; I-0

Rationale:

- Reliability testing was conducted at the critical data element level and performance measure score level. Critical data elements were tested using inter-rater reliability of medical record abstraction. The total population sample size was N=257, however for this specific measure, the sampling N=4 patients was too few to calculate a Kappa. Performance measure score reliability was assessed using the intra-class correlation coefficient (ICC). The developer reported the hospital-level ICC=0.42 (95%CI 0.16-0.73); N=5 hospitals.
- Empirical validity testing was not conducted; only face validity of the performance measure score at the level of the computed measure score. The developer performed systematic face validity assessment (RAND-UCLA Modified Delphi) of whether panelists "would consider providers who adhere more consistently to the quality measure to be providing higher quality care." The panelists concluded there was face validity, although other factors were bundled with the assessment.
- The Committee expressed significant concerns regarding the appropriateness of this measure for the younger age group. It also noted #2806 is measuring two different things—diagnosed with psychosis and comorbid drugs or substance use among children with psychosis—that vary by age group. The developer explained the substance abuse component should have been 12 to 19 years old and the psychosis component should be 5 to 19 years.
- Additionally, the Committee questioned the reliability of urine drug screen tests and requested that the developer consider using non-laboratory screening for substance abuse, particularly for alcohol, which is the most prevalent drug used by adolescents in general and in adolescents who present with psychosis. The Committee sought information on the range of performance variation in younger children compared to older children; the developer explained the younger children were only 5% of sample, which lead the Committee to express concern about the scientific acceptability of the measure for the younger population
- The Committee also asked the developer to restate the denominator to improve clarity and reflect what #2806 actually measures, as well as the accurate population. For example, the denominator is currently "patients 5 to 19 seen in the ED with psychotic symptoms," the Committee suggested a more accurate

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construct might be "patients 5 to 19 discharged from the ED to home or another setting of care." • The Committee specifically noted the measure's reliability appears to be limited to the older population; it was unclear whether #2806 is reliable in the younger age group. • Lastly, the Committee discussed missed opportunities for testing, including data from ED visits where there were psychotic symptoms, but no diagnosis of psychosis at discharge. The developer noted identifying this population of children/adolescents was limited during testing due to the data source used for the measure (i.e., chart data). • NQF #2806 failed on the Validity criterion, in part due to serious concerns with the age ranges of patients specified by the measure. However, Committee members elected to continue their evaluation because the developer indicated it could change the age range and provide new testing data, which would potentially address the age-related validity issues to the Committee's satisfaction; the developer is currently working on these matters.
3. Feasibility: H-11; M-12; L-1; 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: • The Committee had no questions or concerns about the feasibility of this measure.
4. **Usability and Use**: H-3; M-15; L-5; I-1 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The Committee noted this measure is incomplete for the appropriate emergent evaluation of psychosis, since it excludes looking for classes of drugs that are not drugs of abuse. The developer stated its intent was not to work up causes of psychotic symptoms in the ED, but to look for comorbid substance use among children and adolescents with psychosis. The Committee further noted it is important to look for co-occurring substance abuse (or psychosis related to drugs of abuse), but that is only part of the equation. Using a measure that does not include all of the possibilities gives the impression this is all that is necessary to provide quality care. • The Committee highlighted the consequences of having a test that has some unreliable results, including labeling people incorrectly, introducing false negatives, affecting treatment and family dynamics, and missing people who may definitely have an issue or problem.
5. Related and Competing Measures • No related or competing measures noted.
Steering Committee Recommendation for Endorsement: Y-18; N-3 • Because most Committee members felt the age range was the barrier to this measure, and the developer indicated it could readily provide testing results only for the older age group, the Committee continued voting on the criteria even though it failed on Validity. The vote during the in-person meeting on Overall Suitability for Endorsement was taken on the original specifications. • The updated recommendation for endorsement was taken on the revised specification.
6. Public and Member Comment: January 14, 2016 - February 12, 2016 Committee's Recommended Revision: • The Committee requested that the developer revise this measure to limit the population to ages 12-19 (instead of 5-19) and resubmit the new specifications after the comment period. Developer Response to Committee's Recommended Revision: • The developer has revised the measure to include a population of 12-19 years (instead of 5-19). In

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addition, it has updated the title to Adolescent Psychosis: Screening for Drugs of Abuse. The developer has submitted updated specifications and testing materials in a red-lined version of the submission form.

Comments received:

- This measure received one comment that supported the Committee's decision not to recommend the measure, identifying several issues the Committee had mentioned in its discussion, including the age range, the testing of the measure, and the definitions in the measure.

Developer response:

- 1) We agree with the comments from the reviewer and from the committee regarding age range, and therefore submitted the measure to the committee for reconsideration on Feb 26th for a narrower age range (12-19).
- 2) Our response to the psychotic symptom question from the reviewer is similar to our response to the same question in 2805 and is as follows.

  Because patients are identified for measurement retrospectively, the patients with psychotic symptoms are identified based on a coded diagnosis of psychosis at discharge from the inpatient setting. Therefore, psychotic symptoms are defined in the population by their discharge diagnosis. The ICD-9 and ICD-10 codes for the discharge diagnosis set are delineated in the full application.

  The measure specifications, including the ICD-9 codes, were field tested in 209 patients, in an implementation at 3 tertiary care children's hospitals and 2 community hospitals, from Washington State, Ohio, and Minnesota.

  The new proposed denominator definition (changed only in age range):

  "Cases are identified from hospital administrative data.

  Patients aged 12-19 years-old

  ICD-9: Patients have at least one of the following ICD-9 codes for psychosis, as a primary or secondary diagnosis: 291.3, 291.5, 292.11, 292.12, 293.81, 293.82, 295.30, 295.31, 295.32, 295.33, 295.34, 295.40, 295.41, 295.42, 294.43, 295.44, 295.70, 295.71, 295.72, 295.73, 295.74, 295.90, 295.91, 295.92, 295.93, 295.94, 296.24, 296.44, 297.1, 297.2, 297.3, 298.X

  ICD-10: [ICD-10 codes are available in the Excel file referenced in item S.2b.]

  These codes were chosen by Members of the COE4CCN Mental Health Working Group co-chaired by Psychiatric Health Services Researchers Drs. Michael Murphy and Bonnie Zima."
- 3) We addressed the inconsistencies in testing by creating explicit instructions in the abstraction manual when we operationalized the measure. Instructions to chart abstractors are included below for reference. The goal of measurement is in part to create a level of clarity and actionability that can help address inconsistencies in care, which is one part of the rationale for proposing the measure.

  "Patients passing the quality measure are identified during medical record abstraction using the guidelines below.

  Urine Drug Screening /Serum Alcohol Screening – [Module: Psychosis, ED care] This item applies to children and adolescents with psychosis who were admitted to the marker ED. Indicate if the patient had a urine drug screen and/or serum alcohol screen while in the ED. The alcohol test will be a separate test from the drug tests. The drug test must be comprehensive in that it tests for multiple types of illicit drugs. Do NOT give credit for tests that include results of just a single drug. Drug screens commonly include tests for benzodiazepines, barbiturates, methamphetamine, cocaine, methadone, opiates, tetrahydrocannabinol, etc."

Committee response:

- The Committee reviewed the revised measure specifications and testing, and the comment received. The Committee agreed the revised specifications meet the Validity criterion. The Committee voted to recommend the measure for endorsement.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2820 Pediatric Computed Tomography (CT) Radiation Dose
Submission | Specifications
Description: The measure requires hospitals and output facilities that conduct Computed Tomography (CT) examinations in children to: 1. Review their CT radiation dose metrics, 2. calculate the distribution of the results, and 3.compare their results to benchmarks. This would then imply a fourth step to investigate instances where results exceed a trigger value for underlying cause, such as issues with protocol, tech, equipment, patient, etc. It is important to review doses of radiation used for CT, as the doses are far higher than conventional radiographs (x-rays), the doses are in the same range known to be carcinogenic (Pearce, Lancet, 2012; Ozasa, Radiation Research, 2012), and the higher the doses, the greater the risk of subsequent cancer (Miglioretti, JAMA Pediatrics, 2013) Thus the goal of the measure is to provide a framework where facilities can easily assess their doses, compare them to benchmarks, and take corrective action to lower their doses if they exceed threshold values, as per specifications in benchmarks. The measure calls for assessment of doses for the most frequently conducted CT examination types, and compare these doses to published benchmarks. The measure calls for the assessment of radiation doses within four anatomic areas (CT's of the head, chest, abdomen/pelvis and combined chest/abdomen/pelvis.) The measure provides a simple framework for how facilities can assess their dose, compare their doses to published benchmarks (Smith-Bindman, Radiology, 2015) and identify opportunities to improve if their doses are higher than the benchmarks. For example, If a hospital finds their doses are higher than published benchmarks, they can review the processes and procedures they use for performance of CT in children and take corrective action, and follow published guidelines for how to lower doses (such as "child sizing" the doses, reducing multiple phase scans, and reducing scan lengths). Published benchmarks for radiation dose in children exist (Smith-Bindman, Radiology, 2015) and additional benchmarks are under development and will be published within the year by us. (Kumar, 2015) Other groups have also published benchmarks (Goeske) or in the process of doing so. Our work and that of others have shown that institutional review of dose metrics as outlined in this measure results in a significant lowering of average and outlier doses. (Demb, 2015; Greenwood, RadioGraphics, 2015; Miglioretti, JAMA Pediatrics, 2013; Keegan, JACR, 2104; Wilson, ARRS, 2015). This measure is being proposed for diagnostic CT in children, but can also be used for CT in adults, and CT used in conjunction with radiation therapy for cancer. Whenever context the doses are used, the doses should be compared with appropriate benchmarks. A similar measure (#0739) was previously endorsed by the NQF in 2011. The NQF did not provide ongoing endorsement when the measure was up for renewal in 2015, primarily because there was no evidence that assessing doses as called for in the measure would result in an improvement in outcomes (i.e. patient dose). Since that time, there has been additional research that has shown that assessing doses using the format outlined in the measure does indeed result in lower doses, and thus we are re-submitting a similar although updated measure. Of note, the surrogate measure we are using for outcomes is radiation dose. The true outcome of interest is the number of cancers that result from imaging. Because of the lag time between exposure to radiation and cancer development (years to decades) it is not feasible to use cancer cases as the outcome of a quality improvement effort. Thus while there is ample evidence that radiation causes cancer (sited below), and evidenced that cancer risk is proportional to dose, there are no direct data that suggest that lowering doses lowers cancer risk. However,

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we have used mathematical modeling to try to understand the relationship between lowering doses and cancers and estimated that if the top quartile of doses were reduced in children (i.e. the very high doses are brought down the average doses), the number of cancer cases would be reduced by approximately 43%, the equivalent to preventing 4,350 cancer cases / year in the US among children (Miglioretti, JAMA Pediatrics 2013).

Cited in this section:

Demb J, manuscript under preparation. CT Radiation Dose Standardization Across the University of California Medical Centers Using Audits to Optimize Dose. 2015.

Following an in-person meeting regarding CT radiation dose, radiologists, technologists and medical physicists from University of California medical centers strategized how to best optimize dosing practices at their sites, which were then analyzed for effectiveness and success after implementation.

Greenwood T, Lopez-Costa R, Rhoades P, et al. CT Dose Optimization in Pediatric Radiology: A Multiyear Effort to Preserve the Benefits of Imaging While Reducing the Risks. RadioGraphics. Jan 2015;35(5):1539-1554

"This systematic approach involving education, streamlining access to magnetic resonance imaging and ultrasonography, auditing with comparison with benchmarks, applying modern CT technology, and revising CT protocols has led to a more than twofold reduction in CT radiation exposure between 2005 and 2012…" – Conclusion statement from Abstract

Keegan J, Miglioretti DL, Gould R, Donnelly LF, Wilson ND, Smith-Bindman R. Radiation Dose Metrics in CT: Assessing Dose Using the National Quality Forum CT Patient Safety Measure. Journal of the American College of Radiology: JACR; 11(3):309-315.

http://download.journals.elsevierhealth.com/pdfs/journals/1546-1440/PIIS1546144013006625.pdf. Mar 2014

Looking at dose metrics as per compliance with the previously endorsed #0739 NQF measure results in reasonably timed acquisition of CT doses, and seeing such doses resulted in 30-50% dose reduction.

Kumar K, manuscript under preparation. Radiation Dose Benchmarks in Children.

This paper will describe dose metrics among 29,000 children within age strata <1, 1-4 years, 5-9 years, 10-14 years, and 15-19 years. 2015.

Miglioretti D, Johnson E, Vanneman N, Smith-Bindman R, al e. Use of Computed Tomography and Associated Radiation Exposure and Leukemia Risk in Children and Young Adults across Seven Integrated Healthcare Systems from 1994 – 2010. JAMA Pediatrics Published online June 10, 2013 joli:101001/jamapediatrics2013311, 2013.

Radiation-induced cancers in children could be dramatically reduced if the highest quartile of CT radiation doses were lowered.

Miglioretti, YX Zhang, E Johnson, N Vanneman, R Smith-Bindman. Personalized Technologist Dose Audit Feedback for Reducing Patient Radiation Exposure from Computed Tomography. Journal of the American College of Radiology: JACR 2014.

"Personalized audit feedback and education can change technologists' attitudes about, and awareness of, radiation and can lower patient radiation exposure from CT imaging." – Conclusion statement from Abstract

Ozasa K, Shimizu Y, Suyama A, et al. Studies of the mortality of atomic bomb survivors, Report 14, 1950-2003: an overview of cancer and noncancer diseases. Radiation Research; 177(3):229-243. Mar 2012

Fourteenth follow-up report on the lifetime health effects from radiation on atomic bomb survivor showing that: 58% of the 86,611 LSS cohort members with DS02 dose estimates have died, 17% more cancer deaths especially among those under age 10 at exposure (58% more deaths).

Pearce MS, Salotti JA, Little MP, et al. Radiation exposure from CT scans in childhood and subsequent risk of leukaemia and brain tumours: a retrospective cohort study. Lancet;380(9840):499-505. Aug 4 2012

"Use of CT scans in children to deliver cumulative doses of about 50 mGy might almost triple the risk of leukaemia and doses of about 60 mGy might triple the risk of brain cancer… although clinical benefits should outweigh the small absolute risks, radiation doses from CT scans ought to be kept as low as possible" – Conclusion statement from Abstract

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Smith-Bindman R, Moghadassi M, Wilson N, et al. Radiation Doses in Consecutive CT Examinations from Five University of California Centers. Radiology 2015:277: 134–141

"These summary dose data provide a starting point for institutional evaluation of CT radiation doses." – Conclusion statement from Abstract

Wilson N. CT Radiation Dose Standardization Across the Five University of California Medical Centers. ARRS: Annual Toronto Meeting presentation. April 19-24, 2015

Understanding the reasons for variation in commonly performed CT procedures, and figuring out how to standardize them.

Numerator Statement: Radiation Dose metrics among consecutive patients, who have undergone CT of the head, chest, abdomen/pelvis, or chest/abdomen/pelvis. The metrics are 1) mean dose as measured using DLP, CTDIvol, and SSDE: within age strata. And 2) the proportion of exams with doses greater than the 75th percentile of the benchmark you are comparing with for the same anatomic area strata (Kumar, 2015; Smith-Bindman, Radiology, 2015; Goske, Radiology, 2013)

The CTDIvol and DLP are directly reported by the scanner using an "industry wide" standardized dose report (DICOM Radiation Dose Structured Report). The data should be assembled for the entire CT examination. If there are several series, the CTDIvol values should be averaged, and the DLP values should be added.

SSDE can be calculated using any dose monitoring software product, or using published multiplier coefficients which are highly valid.

These different metrics are highly correlated, but nonetheless reveal important differences regarding radiology practice and performance and are thus complimentary. However, if a practice only assesses data from a single metric, there is substantial opportunity for data-driven improvement.

CTDIvol reflects the average dose per small scan length. Modern CT scanners directly generate this.

DLP reflects the CTDIvol x scan length, and is directly generated by modern CT scanners.

SSDE is a modified measure of CTDIvol that takes into account the size of the patient scanned and is useful for scaling dose to patient size. Several current radiation tracking software tools directly report SSDE.

Cited in this section

Goske MJ, Strauss KJ, Coombs LP, et al. Diagnostic reference ranges for pediatric abdominal CT. Radiology. Jul 2013;268(1):208-218.

"Calculation of reference doses as a function of BW (body weight) for an individual practice provides a tool to help develop site-specific CT protocols that help manage pediatric patient radiation doses." – Conclusion statement from Abstract

Kumar K, manuscript under preparation. Radiation Dose Benchmarks in Children.

This paper will describe dose metrics among 29,000 children within age strata <1, 1-4 years, 5-9 years, 10-14 years, and 15-19 years. 2015.

Smith-Bindman R, Moghadassi M, Wilson N, et al. Radiation Doses in Consecutive CT Examinations from Five University of California Centers. Radiology 2015:277: 134–141

"These summary dose data provide a starting point for institutional evaluation of CT radiation doses." – Conclusion statement from Abstract

Smith-Bindman R, Miglioretti DL. CTDIvol, DLP, and Effective Dose are excellent measures for use in CT quality improvement. Radiology. Dec 2011;261(3):999; author reply 999-1000.

An explanation as to why these radiation dose metrics are useful in calculating a patient's absorbed doses.

Huda W, Ogden KM, Khorasani MR. Converting dose-length product to effective dose at CT. Radiology. Sep 2008;248(3):995-1003.

"This article describes a method of providing CT users with a practical and reliable estimate of adult patient EDs by using the DLP displayed on the CT console at the end of any given examination." – Conclusion statement from Abstract

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Denominator Statement: Consecutive sample of CTs conducted in the head, chest, abdomen/pelvis and chest/abdomen/pelvis. No examinations should be excluded

Exclusions: CT examinations conducted in anatomic areas not included above (such as CTs of the extremities or lumbar spine) or that combine several areas (head and chest) should not be included. In children, these four included categories will reflect approximately 80% of CT scans.

Examinations performed as part of diagnostic procedures – such as biopsy procedures – should not be included. CT examinations performed as part of surgical planning or radiation therapy should not be included.

Examinations that are considered "limited abdomen" or "limited pelvis" studies should be included in the abdomen and pelvis category. Any examinations that include any parts of the abdomen and or pelvis should count in the abdomen/pelvis category.

Adjustment/Stratification:

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Imaging Facility, Ambulatory Care : Outpatient Rehabilitation, Ambulatory Care : Urgent Care

Type of Measure: Intermediate Clinical Outcome

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry

Measure Steward: University of California, San Francisco

STEERING COMMITTEE MEETING [12/01/2015-12/02/2015]

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

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

1a. Evidence: H-7; M-16; L-1; I-2; 1b. Performance Gap: H-11; M-14; L-0; I-1

Rationale:

- The Committee agreed this is an intermediate outcome: while it is not possible to show a direct outcome on a particular patient, on a population level the general evidence linking radiation dose to cancer is strong.
- The Committee also noted patients care about radiation dose as an outcome on its own.
- The developer stated most hospitals do not currently tailor their scans to the age of their patients, so children receive the same doses as adults at non-pediatric hospitals—yet a lower dose in a child still produces the same quality of scan. The Committee questioned whether non-pediatric radiologists could properly read lower dose scans, which are “noisier,” but radiologists on the Committee explained a lower dose for children would produce an image of the same quality that occurs for an adult at the higher dose. In other words, using the higher dose in children yields much clearer images for children than radiologists are used to seeing for adults.
- The submission materials noted an earlier version of this measure was not endorsed due to concerns that simply assessing doses was not enough to change them. The developer presented new data, however, demonstrating merely tracking doses alters behavior and lowers an institution’s dose profile for children. According to the developer, dose metrics collected from 2010-2012 showed a 30-50% decrease in variability of doses after an earlier version of this measure was implemented. Five University of California hospitals reported 0-18% reduction after being given strategies to optimize CT doses. Doses have declined 10-30% across all published studies, with the greater reduction shown among sites with higher doses. Additionally, the Committee noted the gap between doses in county hospitals as compared to academic hospitals.
- The Committee agreed the new data demonstrate the measure should lead organizations to address the issue of high doses for children if their doses are higher than national benchmarks, and it should give

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facilities a framework for setting their dose levels. Committee members also noted the measure can be useful internally for a facility to examine its own dose profile over time.

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-5; M-17; L-1; I-3 2b. Validity: H-6; M-16; L-0; I-4

Rationale:

- The Committee raised a number of questions about the specifications and the process of collecting the data, all of which were adequately addressed. The developer explained consecutive exams should be used, and the measure does not include certain procedures (such as radiological oncology). Further, the developer noted this measure only requires that facilities meet the average benchmarks, not that every patient be at or below the benchmark. It also was explained that while there is variability in dose depending on clinical indications, this variability dwarfs the variability from institutional preference. For example, in some situations 1 facility will use a single-phase setting while another will use a multiple-phase setting, which results in twice as much radiation exposure.
- The developer performed empirical testing at the data element level and the performance measure score at 7 integrated health systems and 5 hospitals, from 2012-2014. Overall, more than 115,000 scans were included.
- Reliability testing was done at the level of data elements using several metrics reflecting CT dose indices, including DLP, CTDIvol, and SSDE.
- DLP and CTDI are calculated automatically by all current CT scanners, without variability. Reliability of CT radiation dose metric abstraction (DLP and CTDIvol) was tested through both manual and automated data abstraction, both yielding identical results, perfect Kappa statistics.
- SSDE is a calculated variable that is automatically calculated by dose monitoring programs. Errors from manual calculation were not tested.
- The developer noted nearly 99% of facilities should be able to report on this measure automatically, since any scanner built in the last 10 years reports on the data needed.
- The Kappas for the reliability testing were high (greater than 95%), but on a limited number of sites.
- Empirical testing was performed at the performance measure score. The developer indicated a study was conducted comparing each of the dose metrics with measures of absorbed dose among a sample of 10,000 CT examinations showed a "high correlation," >90%.
- After the developer clarified the questions about the specifications and data collection, the Committee agreed the measure met the Reliability and Validity criteria.

3. Feasibility: H-9; M-12; L-3; I-2

(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:

- Two of the specified metrics (CTDIvol and DLP) are generated as part of clinical CT examinations. Two additional metrics can be calculated from these 2 primary metrics, and these calculations are done within existing software products or can be done manually, or by using various additional approaches. Nearly all facilities (~99%) that perform CT examinations can collect all the measure elements (3 dose metrics: DLP, CTDI and SSDE). Facilities that do not automatically report can use a free software program to compile the data. The Committee agreed this measure is feasible.
- The Committee noted the measure submission states it can be analyzed at the health plan level, but testing data were not provided. Concern also was expressed that plans do not have access to this data and would have to go through providers or get direct access to EMRs. The developer stated testing has been completed at the HMO level, and that certain types of plans, such as those run by integrated health

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systems, can report this measure. The developer acknowledged other plans, such as commercial or Medicaid plans, may not be able to report the measure. After discussion, the developer agreed to remove the health plan level of analysis.
4. Usability and Use: H-10; M-14; L-1; I-1 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The Committee inquired about potential unintended consequences of some patients receiving repeat scans due to the dose being too low. The developer explained this should not be an ongoing problem because, if the dose is set too low and facilities start having to repeat most scans, they will raise the dose. The radiologist on the Committee agreed lowering the dose until it is too hard to read and then increasing it incrementally is a common approach to setting dosage. It was agreed the potential risk for an individual was far lower than the population benefit. • The developer seeks to use the measure for public reporting through the Joint Commission and a University of California San Francisco patient safety project.
5. Related and Competing Measures • No related or competing measures noted.
Steering Committee Recommendation for Endorsement: Y-24; N-2
6. Public and Member Comment: January 14, 2016 - February 12, 2016 Comments received: • This measure received comments from two organizations. One comment noted the importance of education and accountability for following Pediatric Emergency Care Applied Research Network (PECARN) rules; it also noted the importance of clear terms for the measure to assist in implementation. One commenter supported the Committee's recommendation for endorsement. Developer response: • The point made here is a valid and important next step. But first, the adoption of a measure that asks facilities for the standardized collection of data on pediatric CT doses must occur, to help lead to standardizing radiation doses. Physicians who send patients to a facility can then ask that the doses that are used fall within certain accepted standards. Committee response: • Thank you for your comment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals

2842 Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator
Submission | **Specifications**
Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set.

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CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 1, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-1: Caregivers of CMC should report that their child has a designated care coordinator.

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age

2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)

3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

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STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-5**; **M-15**; **L-2**; **I-2**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- For the evidence supporting #2842, the developer provided information on 1 RCT, 1 cohort study, and 5 case series, case control, or historically controlled studies that demonstrated outcomes improve when caregivers of children with medical complex report their child has a designated care coordinator. The RCT timeframe was 6 months and involved 100 children. The Committee felt this time period was quite limited and perhaps insufficient to show improvements in chronic conditions. In addition, the RCT did not specifically focus on including a care coordinator, but on a multi-factorial intervention.
- The developer explained it had operationalized the survey to discover who exactly is coordinating care – whether it was the main provider, someone from the main provider's office, someone from the insurance company, etc. The developer further explained the language for the survey had been developed through a cognitive interview process with families. It noted bundled interventions are more likely to be successful, and it may not be possible nor advisable to extricate individual components. The developer stated evidence for this set of measures comes from the bundled interventions and is stronger for the entire set as opposed to any individual component.
- The Committee noted the patient's perception of whether there is a care coordinator may actually be more important than where the care coordinator is located.
- The developer explained the measures were submitted individually so providers could track their performance and see which areas of care coordination need improvement. It also explained not all of the measures apply to every patient or program, so providers need to be able to focus on the areas that matter to them.
- The Committee raised a concern that, with the measures split out, entities could pick and choose which to report on. The developer explained these measures are health plan or health system level measures, and they are intended to hold the plan or system accountable. The developer added the groups that are currently using this set of measures report they are using the complete survey and set of measures.
- The Committee discussed at length whether the measures should be split or bundled for voting, due to the stronger evidence for some measures within the set, the lack of evidence the measures were stronger as a set than individually, the concerns regarding cherry-picking of some measures, etc. The developer stated users are currently implementing the complete survey, and it was field tested as a whole; based on the testing results, however, the measures were submitted as individual measures and not all items were submitted.
- Ultimately the Committee elected to vote on the measures separately because of questions about either the evidence or validity; it did not want to vote against the entire measure or the majority of measures because of problematic components. Committee members noted voting separately did not preclude requiring the survey as a whole to be completed and reported on when implemented.
- The Committee noted the developer did 6 different literature reviews and all pointed back to the same RCT.
- The Committee elected to vote on performance gap en bloc for the following 8 measures that had passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote applies to all of these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap.
- It also was noted the field test results for #2842 demonstrate a gap in care.

2842 Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator

- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-5**; **M-20**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-1**; **I-1**

<u>Rationale</u>:

- The Committee elected to discuss and vote on Reliability for measures #2842, #2843, #2844, #2845, #2846, #2847, #2848, #2849, #2850, and #2851 in 3 batches based on the information provided. The measures were batched as follows: first batch: #2842; second batch: #2844, #2845, #2846, #2847, #2848, #2850, and #2851; third batch: #2843 and #2849.
- The Committee noted the developers had about 1,200 surveys, but performed reliability testing with 900 surveys. The developer explained it did not have practice-level information for some participants from Washington State Medicaid due to IRB stipulations. It also noted the measure is intended for aggregation at the state level, but the practice grouping was used since the test only included 2 states.
- The developer noted the individuals included in the reliability analysis largely matched the demographic characteristics of the entire group. The developer also compared the scores for the overall sample to the sample used for reliability testing, and found similar scores for all FECC measures with reliability testing (#2842, #2844, #2845, #2846, #2847, #2848, #2849, and #2851).
- The Committee also raised questions about the different sample sizes for the reliability testing. The developer responded this was because the eligibility varies based on responses and people with incomplete information were not included.
- Overall the Committee agreed the measure met the Reliability criterion.
- The Committee did not raise concerns about the validity of measure #2842.

3. Feasibility: H-1; M-21; L-3; 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>:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2842 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2842 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

2842 Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-23**; **N-2**

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. In addition to the comments that applied to all of the FECC measures, the commenter noted strong support for care coordination in its comment for this measure.
- A second organization supported the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.
- NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- *"This is good for the patient, family, subspecialist(s), therapist(s), and PCP. Tracking referrals, medications, therapies, and follow-up appointments can take a burden off of all involved and improve efficiency of care, decrease missed appointments, and reduce costs of redundancy or poor compliance."*
- Thank you; we agree.

Committee response:

- Thank you for your comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2843 Family Experiences with Coordination of Care (FECC) -3: Care coordinator helped to obtain community services

Submission | Specifications

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 3, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-3: Caregivers of CMC who report having a designated care coordinator and who require community services should also report that their care coordinator helped their child to obtain needed community services in the last year.

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age

2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)

3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

2843 Family Experiences with Coordination of Care (FECC) -3: Care coordinator helped to obtain community services

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-2**; **M-17**; **L-3**; **I-1**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- Evidence supporting #2843 was 1 RCT, 1 cohort study, and 5 case series, case control, or historically controlled studies that demonstrated outcomes improve when caregivers of children with medical complex report that their child has a designated care coordinator. The RCT timeframe was 6 months and involved 100 children. The Committee felt this time period was too limited and perhaps insufficient to show improvements in chronic conditions. In addition, the RCT did not specifically focus on including a care coordinator, but on a multi-factorial intervention.
- The developer explained it had operationalized the survey to discover who exactly is coordinating care – whether it was the main provider, someone from the main provider's office, someone from the insurance company, etc. The developer further explained the language for the survey had been developed through a cognitive interview process with families. It noted bundled interventions are more likely to be successful, and it may not be either possible nor advisable to extricate individual components. The developer stated evidence for this set of measures comes from the bundled interventions and is stronger for the entire set as opposed to any individual component.
- It was noted the developer did 6 different literature reviews and all pointed back to the same RCT.
- The Committee elected to vote on performance gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote applies to all of these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2843 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-X**; **M-X**; **L-X**; **I-X** 2b. Validity: **H-1**; **M-22**; **L-2**; **I-0**

<u>Rationale</u>:

- The developer was unable to establish reliability for measure #2843; this was attributed to a small sample size. As per NQF policy, data element level validity was used instead. No vote was taken on the Reliability criterion.

2843 Family Experiences with Coordination of Care (FECC) -3: Care coordinator helped to obtain community services

- The Committee noted the sensitivity and specificity of #2843 were 84 and 92, respectively, at one test site and 89 and 85 at the other, which it considered good. The data element level testing used the algorithm associated with the measure and compared whether the denominators were the same, using clinical chart review as the gold standard (n=700). The Committee noted that the results demonstrated both sensitivity and specificity, at both test sites (Seattle Children's and Washington Medicaid).

3. Feasibility: H-1; M-21; L-3; 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:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2843 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2842 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped

2843 Family Experiences with Coordination of Care (FECC) -3: Care coordinator helped to obtain community services

them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-22**; **N-3**

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. In addition to the comments that applied to all of the FECC measures, the commenter noted this measure is stronger than 2842, since it measures whether the care coordinator actually helped. A second organization supported the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.
- NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- "*This is better than Measure 2842, since it assesses whether the Care Coordinator helped.*"
  We agree that it is important to assess not only whether there was someone helping to coordinate a child's care, but also the quality and perceived value of those services to the family. However, we believe that it is important to assess both items separately, in order to understand the current state of affairs and facilitate improvement. If Measure 2843 were to be used without Measure 2842, it would be unclear whether identified gaps were due to caregivers not having someone to help with care coordination, or if the designated person was failing to assist with specific, important elements of care coordination. The approach to addressing those two separate problems would be quite different.

Committee response:

- Thank you for your comment. The Committee discussed this issue during the in-person meeting in December, but ultimately decided the FECC measures that were recommended assess and meet different needs.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

Submission | **Specifications**

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set.

2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 5, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not..

Numerator Statement:

FECC-5: Caregivers of CMC who report having a care coordinator and who report that their care coordinator has contacted them in the last 3 months should also report that their care coordinator asked them about the following:

- Caregiver concerns
- Health changes of the child

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age

2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)

3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-0**; **M-18**; **L-5**; **I-1**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee noted measure #2844 shared the same evidence base from the single RCT (following 100 children over 6 months) as #2842 and #2843, but did not include other references that had been included for those measures. The developer explained the other studies did not include sufficient detail to determine in some cases precisely what the bundled intervention encompasses. The developer stated that when it was not clear, the study was not cited.
- The Committee noted that, conceptually, having a care coordinator ask about concerns and health changes should be standard and is a practice included in all guidelines for care coordinators.
- The Committee discussed the length of time for contact, with a parent representative on the Committee noting 3 months seemed too frequent. The developer said the literature suggested monthly contact, but it received the same feedback from the parent representative during the development process and so specified quarterly contact.
- The Committee elected to vote on gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote applies to these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2844 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-2**; **M-23**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-0**; **I-0**

<u>Rationale</u>:

- Measure #2844 is a multi-item measure and was tested and reported by analyzing the "within item set alpha," resulting in an alpha of 0.86. Based on the literature, alpha statistics between 0.8 and 0.9 are considered good. The Committee had no concerns with the reliability for #2844.
- Measure #2844 achieved a strong face validity score (8 out of 9) from the developer's Delphi panel. The Committee had no concerns with the face validity.

2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

3. Feasibility: H-1; M-21; L-3; 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:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2844 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2844 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-21**; **N-4**

2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. In addition to the comments that applied to all of the FECC measures, the commenter noted this measure is stronger than 2842, since it measures whether the care coordinator actually helped.
- This measure also received a separate comment supporting the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here. NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- *"This is better than Measure 2842, since it assesses whether the Care Coordinator helped."*
  We agree that it is important to assess not only whether there was someone helping to coordinate a child's care, but also the quality and perceived value of those services to the family. However, we believe that it is important to assess both items separately, in order to understand the current state of affairs and facilitate improvement. If Measure 2844 were to be used without Measure 2842, it would be unclear whether identified gaps were due to caregivers not having someone to help with care coordination, or if the designated person was failing to assist with specific, important elements of care coordination. The approach to addressing those two separate problems would be quite different.

Committee response:

- Thank you for your comment. The Committee discussed this issue during the in-person meeting in December, but ultimately decided the FECC measures that were recommended assess and meet different needs.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals

Submission | Specifications

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 7, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-7: Caregivers of CMC who report having a care coordinator for their child should also report that the care coordinator assists them with specialty service referrals by ensuring that the appointment with the specialty service provider occurs

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age

2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)

3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure did not achieve consensus on the Importance criterion</u>

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

1a. Evidence: **H-0**; **M-14**; **L-7**; **I-3**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- NQF #2845 shares the same evidence base as #2842, #2843, and #2944, as well as additional pre-post design studies that address utilization.
- The Committee raised questions about the timing of this measure, noting it may not be possible to get specialist appointments within 3 months. The developer stated the measure does not require the appointment be held within 3 months. Specifically, the questions are:
    - During the last 12 months, did the main provider tell you that your child needed to see a specialist?
    - If yes, did the person who helped with managing your child's care contact you to make sure your child got an appointment to see a specialist?
- This measure did not achieve consensus on Evidence, but continued to be evaluated.
- The Committee elected to vote on gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote applies to all these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2845 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-2; M-23**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-1**; **I-1**

<u>Rationale</u>:

- Measure #2845 was tested with the Spearman-Brown formula associated with the interclass correlation coefficient, showing a statistically significant variation by practice. The results demonstrated good to excellent (0.74-0.97) reliability, as defined by the literature, depending on the per-entity sample size. The Committee agreed the measure met the Reliability criteria.
- Measure #2845 achieved a face validity score of 7 (out of 9) from the developer's Delphi panel. The Committee did not raise concerns about the validity of measure #2845.

2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals

3. Feasibility: H-1; M-21; L-3; 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:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2845 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2845 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-19**; **N-6**

2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. In addition to the comments that applied to all of the FECC measures, the commenter noted that this measure is stronger than 2842, since it measures whether the care coordinator actually helped.
- This measure also received a separate comment supporting the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here. NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- *"This is better than Measure 2842, since it assesses whether the Care Coordinator helped."*
  We agree that it is important to assess not only whether there was someone helping to coordinate a child's care, but also the quality and perceived value of those services to the family. However, we believe that it is important to assess both items separately, in order to understand the current state of affairs and facilitate improvement. If Measure 2845 were to be used without Measure 2842, it would be unclear whether identified gaps were due to caregivers not having someone to help with care coordination, or if the designated person was failing to assist with specific, important elements of care coordination. The approach to addressing those two separate problems would be quite different.

Committee response:

- Thank you for your comment. The Committee discussed this issue during the in-person meeting in December, but ultimately decided the FECC measures that were recommended assess and meet different needs.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

Submission | Specifications

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 8, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-8: Caregivers of CMC who report having a care coordinator should also report that their care coordinator:

- Was knowledgeable about their child's health
- Supported the caregiver
- Advocated for the needs of the child

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age

2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)

3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-0**; **M-19**; **L-3**; **I-2**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- Again, this measure shares the same evidence base as the prior FECC measures (#2842, #2843, #2844, and #2845). These measures draw on 1 RCT of a multifactorial intervention focusing on improving outcomes for CMC; it included 100 children followed over 6 months. Three additional studies cited also show that outcomes improve when care coordinators are knowledgeable, supportive, and good advocates for the child's needs.
- The Committee agreed #2846 conceptually is the essence of care coordination, and accountability for providing a care coordinator who is knowledgeable, supportive, and advocates for the patient is important. Committee members raised questions about how the measure is operationalized; the developer reviewed the questions and explained the scoring system, noting the measure is a composite. The developer also explained providers can receive either full or partial credit on any of the items, which are then rolled up to a total score.
- The developer further noted if patients/caregiver answered don't know, skipped, or refused to answer a question needed for scoring the measure, that survey was removed from the calculations, since the developer did not feel it was appropriate to hold entities accountable for something a respondent may actually legitimately not know (e.g., that a care coordinator was working behind the scenes to help make appointments).
- The Committee discussed whether this measure, #2846, should be combined with #2842 (Has Care Coordinator), since #2846 is the most desirable outcome. The developer explained the 2 measures had been split so as not to penalize health plans twice if care coordinators were not provided, since there is a gap in performance on #2842.
- The Committee elected to vote on gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote applies to all these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2846 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-2**; **M-23**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-1**; **I-1**

<u>Rationale</u>:

- Measure #2846 is a multi-item measure and was tested and reported by analyzing the "within item set alpha," resulting in an alpha of 0.73. Based on the literature, alpha statistics between 0.7 and 0.8 are considered acceptable. The Committee had no concerns with the reliability of #2846.
- Measure #2844 achieved a face validity score of 7-8 (out of 9) from the developer's Delphi panel. The developer indicated these results demonstrate convergent validity between #2846 and the CAHPS items that also would be expected to be influenced by the quality and degree of care coordination assistance a parent receives for a CMC. The Committee had no concerns with the validity testing.

2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

3. Feasibility: H-1; M-21; L-3; 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:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2846 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2846 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-24**; **N-1**

2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. In addition to the comments that applied to all of the FECC measures, the commenter noted that this measure is a patient satisfaction measure that supports family engagement.
- This measure also received a separate comment supporting the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.
- NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- *"This is a patient satisfaction process measure that support family engagement."*
  We agree. As part of our measure development process, we conducted several focus groups with caregivers of children with medical complexity. Through this formative work we determined the importance of evaluating caregiver experiences with care coordination services as they relate to supporting family engagement in their child's care.

Committee response:

- Thank you for your comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content

Submission | Specifications

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA), which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 9, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-9: Caregivers of CMC who report receiving a written visit summary during the last 12 months from their child's main provider's office should report that it contained the following elements:

- Current problem list
- Current medication list
- Drug allergies
- Specialists involved in the child's care
- Planned follow-up
- What to do for problems related to outpatient visit

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age
2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)
3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure did not achieve consensus on the Importance criterion</u>

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

1a. Evidence: **H-0**; **M-11**; **L-11**; **I-2**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- NQF #2847 focuses on whether an after-visit summary was provided and included 6 key components: a problem list, a current medication list, drug allergies, specialist involved in care, planned follow-up, and what to do if there are problems related to the outpatient visit. The Committee noted much of the discussion during the workgroup call had centered on whether these are the correct 6 components.
- The Committee questioned how this measure ties into Meaningful Use, especially since this list is more comprehensive than the after-visit summary required by Meaningful Use. While the developer understood the Meaningful Use concerns, it also noted families encouraged the developer to include these various items within the measure.
- This measure did not achieve consensus on Evidence, but evaluation continued.
- The Committee elected to vote on gap *en bloc* for the following 8 measures: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion, and that vote applies to all these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2847 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-2**; **M-23**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-1**; **I-1**

<u>Rationale</u>:

- The developer stated this measure performed the highest in the validation analyses when compared with 4 different CAHPS measures.
- Measure #2847 is a multi-item measure and was tested and reported by analyzing the "within item set alpha," resulting in an alpha of 0.86. Based on the literature, alpha statistics between 0.8 and 0.9 are considered good. The Spearman-Brown formula associated with the interclass correlation coefficient showed a statistically significant variation by practice. The results demonstrated good to excellent (0.46-0.90) reliability depending on the per-entity sample size. The Committee had no concerns with the reliability for #2847.
- Measure #2847 achieved a validity score of 7-8 (out of 9) from the developer's Delphi panel. The Committee had no concerns with the validity testing.

2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content

3. Feasibility: H-1; M-21; L-3; 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:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2847 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2847 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability, but did note there could be problems with usability due to Meaningful Use, both in that this requires more than Meaningful Use does and there have been problems with "gaming," (i.e., setting EHRs to include information in discharge summaries that was not discussed with the patient).

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content

Steering Committee Recommendation for Endorsement: **Y-18**; **N-7**

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section; there were no new points specific to this measure. This measure also received a separate comment supporting the Committee's recommendation for endorsement.

Developer response:

- Please note that responses are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.

Committee response:

- Thank you for your comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2849 Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed

Submission | **Specifications**

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA)1, which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 1, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

2849 Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-15: Caregivers of CMC who self-identify as having a preference for conducting medical visits in a language other than English should have access to a professional medical interpreter (live or telephonic) at all visits for which an interpreter is needed.

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age
2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)
3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-5**; **M-19**; **L-0**; **I-0**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee expressed concern that #2849 focuses on professional translation and noted a measure of general cultural competency also is needed.
- Committee members noted providing translation services is a legal requirement and, if not provided, providers are not following the law. The developer explained, and several Committee members concurred, that despite the law, much evidence exists that some institutions are not using professional translators to communicate with families with limited English proficiency; children or non-medical professional staff (e.g., housekeeping) are sometimes used.
- It was noted translation is a critical healthcare service, and it should be possible to extrapolate from the general body of evidence for this measure.

2849 Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed

- The Committee elected to vote on gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion, and that vote applies to these measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2849 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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-X**; **M-X**; **L-X**; **I-X** 2b. Validity: **H-0**; **M-18**; **L-5**; **I-2**

<u>Rationale</u>:

- The developer was unable to establish reliability for measure #2849; this was attributed to a small sample size. As per NQF policy, data element level validity was used instead. No vote was taken on the Reliability criterion.
- The Committee raised concerns about the validity of this measure, in particular the results of the convergent validity testing, which did not show a significant association with overall provider rating (adjusted or unadjusted) or with getting all the care coordination help needed (unadjusted).
- Committee members did note convergent validity testing is likely less appropriate for this measure, and this measure had the highest face validity of the measures in this set (8 out of 9). The developer noted #2849 was also associated with significantly better experience in terms of access to care, with some of the largest beta coefficients of all the FECC measures, in both unadjusted and adjusted analyses.

3. Feasibility: H-1; M-21; L-3; 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>:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2849 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible to collect the data. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

<u>Rationale</u>:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2849 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

2849 Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-22**; **N-3**

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- This measure received two supportive comments, one noting that it is "essential" to the provision of high quality care. However, that comment also noted this can only happen in systems where a care coordinator position exists and is supported, as discussed in Theme 2: Family Experiences with Coordination of Care Measures section.

Developer response:

- Please note that responses are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.

Committee response:

- Thank you for your comment.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Board of Directors Vote: Y-X; N-X

9. Appeals

2850 Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan

Submission | **Specifications**

Description: The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years

2850 Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan

with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 10 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA)1, which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 10 of the FECC quality measures; this submission relates to FECC 16, described below. The short descriptions of each quality measure follows:

FECC-1: Has care coordinator

FECC-3: Care coordinator helped to obtain community services

FECC-5: Care coordinator asked about concerns and health changes

FECC-7: Care coordinator assisted with specialist service referrals

FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs

FECC-9: Appropriate written visit summary content

FECC-14: Health care provider communicated with school staff about child's condition

FECC-15: Caregiver has access to medical interpreter when needed

FECC-16: Child has shared care plan

FECC-17: Child has emergency care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not.

Numerator Statement:

FECC-16: Caregivers of CMC should report that their child's primary care provider created a shared care plan for their child.

Denominator Statement: The eligible population of caregivers for the FECC Survey overall is composed of those who meet the following criteria:

1. Parents or legal guardians of children 0-17 years of age
2. Child classified as having a complex, chronic condition using the Pediatric Medical Complexity Algorithm (PMCA) (see Simon TD, Cawthon ML et al. 2014)
3. Child had at least 4 visits to a healthcare provider over the previous year

While some of the FECC measures only apply to a subset of the overall eligible population for the survey (e.g., measures related to the quality of care coordination services provided are only scored for those caregivers who endorse having a care coordinator), eligibility for these quality measures can only be gleaned from responses to the FECC Survey itself. This is analogous to the situation with many H-CAHPS measures, where, for example, measures about blood draws and laboratory testing are scored only for those who had the relevant service performed during the time frame or hospitalization in question.

Exclusions: Denominator exclusions:

1. Child had died
2. Caregiver spoke a language other than English or Spanish

Adjustment/Stratification:

Level of Analysis: Health Plan, Population : State

Setting of Care: Other

Type of Measure: Process

2850 Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan

Data Source: Administrative claims, Patient Reported Data/Survey

Measure Steward: Seattle Children's Research Institute

STEERING COMMITTEE MEETING [12/01/2015]

1. Importance to Measure and Report: <u>The measure meets the Importance criterion</u>

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

1a. Evidence: **H-12**; **M1-11**; **L-1**; **I-0**; 1b. Performance Gap: **H-0**; **M-25**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee noted this measure had a particularly strong evidence base, with 7 RCTs, 3 cohort studies, 7 case series studies, and 2 consensus statements (including 1 from AAP), all showing better outcomes with shared care plans.
- The Committee requested additional information on how much commonality exists between the definitions of a shared care plan in the studies. The developer explained it was limited by the information provided in the studies, but it conceptualized the shared care plan for this measure, as follows:
    - Needed to be described as a shared care plan or an individualized plan tailored to that particular patient and/or family.
    - Needed to be developed by the patient and family in conjunction with the primary care provider or a care coordinator and then shared with a primary care provider.
    - Could also incorporate other providers in a multi-disciplinary team.
- One Committee member noted shared care plans often are not updated, which can lead to unintended, negative consequences, such as giving the wrong medication or wrong dose. The developer stated it had looked at a measure focused on whether the care plan had been updated in the last year. It found that despite relatively poor performance overall—about 40% of children had a shared care plan—the performance on additional details, such as having been updated in the last year, was good. The developer decided the data suggested it was not worth measuring subparts, such as updating, at this time, although it might in the future when more children have care plans.
- The Committee elected to vote on gap *en bloc* for the following 8 measures that passed Evidence: #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850. Accordingly, there was a single discussion and vote for this subcriterion and that vote that applies to these recommended measures.
- The Committee agreed a gap in care coordination for CMC exists and there is consensus that this is an important topic to measure, but there are limited data and a lack of consensus on the size of the gap. It also was noted the field test results for #2850 demonstrate a gap in care.
- It was generally agreed that while CMC are a small population, this is a high-risk population and care coordination for these children has a significant impact.

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

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

2a. Reliability: **H-2**; **M-23**; **L-0**; **I-0** 2b. Validity: **H-2**; **M-21**; **L-1**; **I-1**

<u>Rationale</u>:

- Measure #2850 was tested with the Spearman-Brown formula associated with the interclass correlation coefficient, showing a statistically significant variation by practice. The results demonstrated good to excellent (0.80-0.98) reliability depending on the per-entity sample size. The Committee agreed the measure met the Reliability criteria.
- Measure #2850 achieved a face validity score of 7 (out of 9) from the developer's Delphi panel. The Committee did not raise concerns about the validity of measure #2850.

3. Feasibility: H-1; M-21; L-3; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to

2850 Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan

inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so feasibility for these 8 measures was discussed and voted on *en bloc*. Measure #2850 was judged feasible.
- The Committee noted the data are currently collected via caregiver survey, which is expensive and time-consuming; as a plan-level measure, however, it should be feasible. The Committee also acknowledged the developer's view that surveys are currently the most valid approach for collecting data on the quality of care for CMC. Administrative data (billing data) are used to identify children eligible for the denominator population.

4. Usability and Use: H-2; M-18; L-5; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- Measures #2842, #2843, #2844, #2845, #2846, #2847, #2849, and #2850 are encompassed within the same survey instrument, so Usability and Use for these 8 measures was discussed and voted on *en bloc*. Measure #2850 was judged usable.
- This measure is currently in use for internal quality improvement by a number of organizations, including children's hospitals, universities, and health plans.
- The Committee raised no major concerns with the overall usability.

5. Related and Competing Measures

- The following measures are related and not harmonized:
- 0009 : CAHPS Health Plan Survey v 3.0 children with chronic conditions supplement
- 0718 : Children Who Had Problems Obtaining Referrals When Needed
- 0719 : Children Who Receive Effective Care Coordination of Healthcare Services When Needed

According to the developer:

- The currently available NQF-endorsed measures related to care coordination and care for children with chronic conditions are related to, but fundamentally different from, the quality measures addressed in the FECC measure set.
- The measures differ with regard to target population. The currently-endorsed measures address children with chronic conditions (0009), children who have received a referral to specialty services (0718), and children who received care from at least 2 types of health care services (0719). The FECC measures address children with medical complexity. While the other measures likely apply to CMC (in addition to many other children), the FECC measures are specific to CMC.
- The FECC measures differ from currently-endorsed measures with regard to focus. The currently-available measures largely focus on whether families who needed specialized services for their child found it easy or difficult to obtain them and whether anyone in their health plan or child's doctor's office/clinic helped them to get that service. The FECC measures focus more on the quality of services provided by a family's self-identified care coordinator, delving into the specific care coordination attributes and processes that have been associated with better outcomes in the literature.

Steering Committee Recommendation for Endorsement: **Y-22**; **N-3**

6. Public and Member Comment: January 14, 2016 - February 12, 2016

Comments received:

- One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2: Family Experiences with Coordination of Care Measures section. For this measure, the commenter noted

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the need for a basic Shared Care Plan in the public domain that "could be widely adopted to move toward standardization and adapted to an electronic format. We have concerns about a provider's ability to do this for all patients with medical complexity, especially in light of the potential difficulty of including some subspecialists in the creation of a shared care plan." As with some of the other measures in this set, the commenter stated this measure is stronger than 2842, since it measures whether the care coordinator actually helped and highlighted the need for supported care coordinator positions. This measure also received a separate comment supporting the Committee's recommendation for endorsement.

Developer response:

- Note that responses to the portions of the comment that were submitted on multiple measures are included in Theme 2: Family Experiences with Coordination of Care Measures section and are not repeated here.
- NOTE: This developer has elected to pull out and respond separately to each point of the comments received. The italicized sections in quote marks are quoted from the original comment. The developer's response follows.
- *"This can only happen in systems where a Care Coordinator position is available and reimbursed. This is only sustainable if the practice has support from the health plan or other sources."*

  This FECC Survey measure assesses whether caregivers of children with complex needs report that their child's main provider created a shared care plan for their child during the last 12 months. A "shared care plan" is defined for the survey respondent as follows: "A shared care plan is a written document that contains information about your child's active health problems, medicines he or she is taking, special considerations that all people caring for your child should know, goals for your child's health, growth and development, and steps to take to reach those goals." The "main provider" is defined for the survey respondent as follows: "Your child's main provider is the doctor, physician assistant, nurse or other health care provider who knows the most about your child's health, and who is in charge of your child's care overall." Thus, fulfillment of this quality measure does not require that the child have a care coordinator and thus does not require that the system in which the child receives care has care coordinator positions available or reimbursed. This measure assesses the care being provided by the child's main healthcare provider, not the services being provided by a care coordinator.
- *"It would be tremendously helpful if there were a basic Share Care Plan available in the public domain, which could be widely adopted to move toward standardization and adapted to an electronic format. We have concerns about a provider's ability to do this for all patients with medical complexity, especially in light of the potential difficulty of including some subspecialists in the creation of a shared care plan."*

  The quality improvement interventions suggested here by the commenter would certainly go a long way toward improving performance on this measure which had one of the lower scores in our FECC measure field test with only 44% of the 1209 participating families reporting their child had such a plan. We found in our two state field test of this measure, that primary care providers caring for children with medical complexity on average have very few (< 10) of these children in their practices, thus we disagree that creating shared care plans for these children would be a burdensome task for any single provider especially given the measure has no requirement for how often the plan is updated. The measure only assesses whether such a plan was developed for the child by their main provider during the last 12 months. While including subspecialists in the creation of such a plan would likely make it a more comprehensive document, the proposed quality measure does not require or specify that subspecialists be included in the creation of the plan.

  Given the evidence supporting this quality measure, the benefits of instituting it to drive improvement on this aspect of care for children with medical complexity would seem to outweigh the risks. The evidence supporting this measure is laid out in section 1a.8.2 of the evidence summary attachment. Briefly, seven randomized controlled trials, 3 non-randomized controlled trials, 6 uncontrolled interventions with a pre-post comparison, a non-systematic review including unpublished program evaluations, and a consensus

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statement from the AAP support that interventions that include a shared care plan are associated with improved health and healthcare outcomes among children and adults with chronic disease or medical complexity. • *"This is better than Measure 2842, since it assesses whether the Care Coordinator helped."* As outlined above in our response to the first comment related to Measure 2850, this measure does not assess services provided by a care coordinator. It assesses care being provided by the child's main provider defined for the survey respondent as follows: "Your child's main provider is the doctor, physician assistant, nurse or other health care provider who knows the most about your child's health, and who is in charge of your child's care overall." It is the child's main provider who is held accountable for developing the shared care plan with the family not the child's care coordinator. Measure 2842 is different but equally important in that it requires that children with medical complexity have a care coordinator. Without a care coordinator, many aspects of a shared care plan developed by the child's main provider will likely not be successfully implemented. Committee response: • Thank you for your comment.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Board of Directors Vote: Y-X; N-X
9. Appeals