NATIONAL QUALITY FORUM

Memo

TO: Pediatrics Health Steering Committee

FR: NQF Staff

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

DA: February 22, 2016

Purpose of the Call

The Pediatrics Health Steering Committee will meet via conference call on **Friday, February 26, 2016, from 1:00-3:00 PM ET**. The purpose of this call is to:

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

Due to time constraints, we will review comments by exception, discussing those cases where the Committee disagrees with the proposed responses.

Steering Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
3. Review and re-discuss the measure where consensus was not achieved to see if consensus can be reached.
4. Review and consider the requests for reconsideration and the materials provided.
5. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

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

Speaker dial-in #:	(844) 729-4895
Web Link:	http://nqf.commpartners.com/se/Rd/Mt.aspx?163089
Registration Link:	http://nqf.commpartners.com/se/Rd/Rg.aspx?163089

Background

A healthy childhood sets the stage for better health and quality of life in adulthood. There are about 75 million children under 18 years 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 has undertaken 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. The Committee recommended 14 measures for endorsement, did not reach consensus on 1 measure, and did 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.

Comments Received

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

Pre-evaluation comments

The pre-evaluation comment period was open from November 6 – 20, 2015, for the 24 measures under review. NQF did not receive any pre-evaluation comments during this comment period.

Post-Evaluation Comments

The draft report was made available for member and public comment from January 14, 2016, through February 12, 2016. During this period, NQF received 45 comments from three member organizations:

Consumers – 0

Purchasers – 0

Providers – 2

Supplier and Industry – 0

Professional – 1

Health Plans – 0

QMRI – 0

Public & Community Health – 0

Although all comments are subject to discussion, the intent is not to discuss each individual comment on the February 26th post-comment call. Instead, we will spend the majority of the time considering the measure that did not reach consensus, the requests for reconsideration, and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, please note measure developers were asked to respond where appropriate.

We have included all comments that we received in the excel spreadsheet posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and the developer or NQF response, where appropriate. ***Please review this table in advance of the call and consider the individual comments received and the proposed responses to each.***

Comments and Their Disposition

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

1. Support for Committee recommendations
2. Comments on the set of Family Experience with Care Coordination (FECC) Measures
3. Lack of access to care

Theme 1 – Support for Committee Recommendations

Overall, the comments received supported the Committee's recommendations (either for or against endorsement) on the measures. Several of the comments noted concerns with the measures or provided suggestions for improvement. These are detailed under the 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) measure set (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 way to determine the population to include in the measure.

While the commenter did note the importance of care coordination and family engagement, it also raised more general concerns with the logistics of care coordination. Specific 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, and a request for information how the measure supports the Medical Home where the primary care physician is not part of the network, but has his or her own care coordinator.

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 under each individual measure.

Developer Response:

"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.)

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider their recommendation on any of the measures in the FECC set?

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

Recommended Measures

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

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.

Proposed Committee Response:

Thank you for your comment.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2789?

2797: Transcranial Doppler Ultrasonography Screening Among Children With Sickle Cell Anemia

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 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.

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2797?

2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics

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 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".

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response**.**

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2800?

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

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.

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2801?

2803: Tobacco Use and Help with Quitting Among Adolescents

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.

Proposed Committee Response:

To be discussed on the 2/26 call.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2803?

2820: Pediatric Computed Tomography (CT) Radiation Dose

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.

Proposed Committee Response:

Thank you for your comment.

> **Action Item**: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2820?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. 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 above under Theme 2** and are not repeated here.)

"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.

Proposed Committee Response:

Thank you for your comment.

> **Action Item**: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2842?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. 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 above under Theme 2 and are not repeated here.)

"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.

Proposed Committee Response:

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

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2843?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. 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 above under Theme 2 and are not repeated here.)

"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.

Proposed Committee Response:

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

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2844?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. 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 above under Theme 2 and are not repeated here.)

"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.

Proposed Committee Response:

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

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2845?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. 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 above under Theme 2 and are not repeated here.)

"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.

Proposed Committee Response:

Thank you for your comment.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2846?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above; 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:

Responses are included under Theme 2, above.

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2847?

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

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.

Developer Response:

Responses are included under Theme 2, above.

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2849?

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

One commenter submitted a series of similar comments on the FECC measures, discussed in Theme 2 above. For this measure, the commenter noted 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 above under Theme 2 and are not repeated here.)

"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 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.

Proposed Committee Response:

Thank you for your comment. The developer has been asked to provide a response.

> **Action Item:** After reviewing the comments received, and the developer’s response, does the Committee wish to reconsider its recommendation on measure 2850?

Consensus Not Reached

2807: Pediatric Danger to Self: Discharge Communication with Outpatient Provider

The Committee did not achieve consensus on this measure during the meeting for several of the criteria. The developer did not submit additional information to address the issues raised during the discussion. During the Validity discussion, the Committee expressed concerns about identifying the primary provider; information not documented appropriately to actually calculate the rate; and communication within institutions, particularly with confidentiality interfering with the types of communication that happens within and outside of institutions. The Committee noted the significant performance gap reported by the developer about the low rate of communication, which could have been attributed to a validity issue—i.e., that it was not documented or that it did not happen. The vote was H-0; M-12; L-12; I-0.

In addition, the Committee did not achieve consensus on Feasibility (H-0; M-12; L-12; I-0), with concerns about testing that required trained nurse extractors and documenting all calls and emails. Consensus also was not reached on Usability and Use (H-1; M-10; L-12; I-1). The Committee expressed concerns about the challenges of documentation and accessibility to information, particularly that some types of communications, such as email, might not be HIPAA compliant due to security issues. Finally, the overall recommendation did not achieve consensus: Y-10; N-14 (42%-58%).

This measure received one comment that noted it covers an important topic, but raising concern that the measure is “not yet ready for prime time” and suggesting improvements. This measure also received a comment requesting more information from NQF regarding the next steps for a “consensus not reached” measure.

Developer Response:

We appreciate the reviewer’s acknowledgment that this is an important area and that it should be a goal for all discharges. While there may be limitations in the current forms of documentation (lack of inclusion in the clinical document architecture [CDA]) and forms of communication (HIPAA-compliant DIRECT messaging systems that are not widely available), the timeline for improving on these systems is not clear. Given the severity of illness for this vulnerable population and the consensus regarding the importance of adequate communication for all populations, this measure is an important stop-gap while we wait for improvements in documentation and communication systems.

NQF Response:

Consensus not reached is an NQF designation for measures that receive between 40-60% approval from Committees during their review process. Measures not reaching consensus are listed as such in the draft report, and comments are specifically sought on these measures. The developer also is invited to provide additional information to address concerns raised during the Committee’s discussion.

Following the review of this information, the Committee is asked to discuss the measure during the post-comment call and then revote on the measure to see if consensus can be reached. If the measure is then recommended, it moves forward with the other recommended measures to NQF Member Vote. If the measure is not recommended, the measure does not move forward to Member Vote. If consensus is still not achieved, the measure will move forward to NQF Member Vote as consensus not reached, and the NQF membership will be asked to weigh in.

> **Action Item:** The Committee should review the comments received and the developer response, and then revote on the measure to see if consensus can be reached.

Measures Not Recommended

2802: Overuse of Imaging for the Evaluation of Children with Post-Traumatic Headache

Two organizations supported the Committee's decision not to recommend this measure. One comment identified several issues the Committee had mentioned in its discussion, such as the level of analysis and the inclusion of headache. The second commenter supported the committee's deliberations, but requested more information: "[We] encourage further committee discussion (or clarification) as to whether a lack of testing in smaller populations warrants not moving it forward. Further, if the decision remains, is this an example of a "continued development/testing." It was unclear as to when that decision could be applied."

Developer Response:

Although we were unable to test the measure at the hospital/ED level, we agree that this quality measure would be appropriate for this level. We also agree that a more inclusive list of "concussion" or "head injury" ICD-9/10-CM code set of inclusion criteria would be more appropriate for capturing the population clinically. However, as a Center of Excellence for the Pediatric Quality Measures Program, our assignment from the Centers for Medicare & Medicaid Services was to address overuse of imaging for headache.

Proposed Committee Response: To be discussed on the 2/26 call.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2802?

2805: Pediatric Psychosis: Timely Inpatient Psychiatric Consultation

One commenter supported the Committee's decision not to recommend this measure, concurring with issues the Committee had mentioned in its discussion, including concerns with the definitions in the measure. A second comment also was received, that requested more information about the Committee's rationale:

> "We support the committee's deliberations, but encourage further committee discussion (or clarification) on a rationale provided. Specifically, "whether it could be operationalized in less specialized hospital settings (e.g., general hospitals that are not pediatric-specific)." The vulnerability of this population should be considered when applying assumptions about the ability to operationalize timely consultation. Further, we would like the committee to revisit the rationale of not moving this measure forward because some hospital settings may not have EHR; this rationale could be relevant to other previously endorsed measures."

Developer Response:

Thank you to the AAP for reviewing and commenting on the pediatric measure set and the measures (2805, 2806, and 2807) regarding mental health in particular.

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 an implementation at 3 children's hospitals across 253 patients.

The denominator definition we used is as follows:

Cases are identified from hospital administrative data. Patients aged =5-=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, 298.0, 298.1, 298.2, 298.3, 298.4, 298.8, 298.9

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 (see Ad.1) co-chaired by Psychiatric Health Services Researchers Drs. Michael Murphy and Bonnie Zima.

Patients were included regardless of source of admission (from ED, direct admission, or transferred from outside hospital).

Proposed Committee Response: To be discussed on the 2/26 call.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2805?

2815: CAPQuaM PQMP Mental Health Follow Up Measure Timeliness 1: Delayed coordination of care following mental health discharge

This measure received one comment agreeing with the Committee's decision not to recommend the measure and noting concern with the measure, including a lack of evidence for the 30-day window and a lack access to follow up care.

Proposed Committee Response:

Thank you for your comment.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2815?

2818: ADHD Chronic Care Follow-up

This measure received one comment from the American Academy of Pediatrics agreeing with the Committee's recommendation not to endorse. The comment noted that the measure is not ready for use, and raised concerns with the lack of evidence for the 30-day window as well as a "lack of consideration regarding access to appropriate follow-up care". Further, the comment noted that appropriate follow up should be a goal with all discharges, no matter what the diagnosis, and that follow ups and hand-offs are comment pitfalls in ensuring compliance and preventing reoccurrence of illness.

Developer Response:

The AAP, in its capacity as measure steward on behalf of the AHRQ-CMS PQMP PMCoE, respects the concerns AAP members raised regarding this measure.

Regarding the comment related to concerns about data collection & analysis: This measure is an administrative claims-based measure and includes codes for E&M visits in the specifications. E&M codes are also used for well child visits. Therefore, this measure has a provision such that ADHD follow-up for well controlled patients can occur at annual well visits.

Regarding the comment related to a lack of data demonstrating a strong relationship to improved health: The PMCoE Consortium based this measure on the 2011 AAP AHDH Clinical Practice Guideline, in which this standard of recommended care quality was designated as a strong recommendation: “The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).” It is recommended that children and youth with special health care needs be seen at least 1 time in a year as needed to coordinate care according to the Medical Home Model. Providing “care that promotes strong partnerships and honest communication is especially important when caring for children and youth with special health care needs.” There is evidence that ADHD treatment can improve the likelihood of a positive outcome and reduce the negative consequences of ADHD in the short term; however, residual benefits of pharmacological treatment may subside when medication is discontinued.[1] Therefore, given that ADHD symptoms may manifest for as long as 8 years after diagnosis and that ADHD treatment has been shown to work in the short-term although it may require many modifications, regular ADHD follow-up care is to ensure that a child is adhering to a treatment plan.

1. Barkley R, Fischer M, Edelbrock C, Smallish L. The adolescent outcome of hyperactive children diagnosed by research criteria: an 8-year prospective follow-up study. *J AM Acad Child Adolesc Psychiatry.* 1990;29(4):546-557.

Proposed Committee Response:

Thank you for your comment.

> **Action Item**: After reviewing the comments received, and the developer’s response, does the Committee wish to reconsider its recommendation on measure 2818?

2848: Family Experiences with Coordination of Care (FECC-14: Health care provider communicated with school staff about child’s condition

This measure received one comment agreeing with the Committee’s decision not to recommend the measure. The comment noted concerns with the measure, stating the definition is too broad and would not be feasible for implementation. It also raised the same concern as with the other care coordination measures, regarding the need for system support for care coordinators, as discussed above in Theme 2.

Developer Response:

"This definition is too broad (difficulty learning, understanding, or paying attention in class) and it is not feasible for this to be done as written."

As part of the measure development process (described in section 2b2.2 of the testing attachment), cognitive interviews were performed with caregivers of children with medical complexity, in English and Spanish, to assess their understanding and interpretation of the survey items. These interviews revealed that there was consistent caregiver understanding of what was meant by the survey items used to assess this measure.

"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."

For this measure, the contact with the school could be initiated by anyone in the main provider's office; having a designated care coordinator, or even an individual identified as helping the caregiver to manage the child's care, is not required. There are therefore multiple ways in which a medical home might provide this service, even in the absence of support for a care coordinator position.

Proposed Committee Response:

Thank you for your comment.

> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure 2848?

2851: Family Experiences with Coordination of Care (FECC) -17: Child has emergency care plan

This measure received one comment agreeing with the Committee's decision not to recommend the measure. Problems highlighted in the comment included the prior issue discussed in Theme 2 of the need for system support for care coordinators; the need for the PMCA to be updated to include ICD-10 and SNOMED codes; and a request for the data demonstrating a relationship to improved health. In addition, the commenter noted the need within the pediatric community for "a standardized Emergency Care Plan which is available in the public domain, widely adopted, and has the ability to be adapted for EHR incorporation before we add burdens of support for this among PCPs. While in theory this is great, ideally it would be electronic, part of a CDA, and available to parents and other caregivers at all times on a portal or phone for access."

Developer Response:

"We believe the pediatric community needs a standardized Emergency Care Plan which is available in the public domain, widely adopted, and has the ability to be adapted for EHR incorporation before we add burdens of support for this among PCPs. While in theory this is great, ideally it would be electronic, part of a CDA, and available to parents and other caregivers at all times on a portal or phone for access."

The quality improvement interventions suggested here by the commenter would certainly go a long way toward improving performance on this measure, which had some of the lowest scores in the FECC measure field test among 1209 families of children with medical complexity across 2 states.

“This may not be feasible to do for all medically complex children, and for some it may not even be necessary.”

We agree that the evidence supporting this measure is weak, despite the calls for all children with special health care needs to have such plans. This measure was primarily based on an AAP policy statement suggesting that this should be a standard of care.

“Where are the data demonstrating a relationship to improved health?”

The evidence supporting this measure is laid out in section 1a.8.2 of the evidence summary attachment. Briefly, an RCT with poor follow-up, a manuscript describing an intervention and reporting improved outcomes but with an unclear comparison group, and 2 consensus statements from the American Academy of Pediatrics support the importance of having an emergency care plan for children with complex medical problems for optimizing outcomes. Overall, the empirical evidence is of moderate to low quality, with fairly strong expert consensus from the AAP.

Proposed Committee Response:

Thank you for your comment.

> **Action Item:** After reviewing the comments received, and the developer’s response, does the Committee wish to reconsider its recommendation on measure 2851?

Requests for Reconsideration

Two developers submitted requests for reconsideration of their measures. NQF’s policy permits a developer to request reconsideration of a measure not recommended by the Committee during the in-person meeting. To promote consistency, transparency, fairness, and completion of the Consensus Development Process within project timelines, there are two reasons that may justify a request to reconsider a measure that is not recommended for endorsement:

- NQF’s measure evaluation criteria were not applied appropriately, or
- NQF’s CDP was not followed.

2799: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
National Committee for Quality Assurance

NCQA is requesting reconsideration of measure 2799; they believe the additional materials supplied demonstrate the validity of the measure.

Initial Committee Consideration:

The Committee did not reach consensus on the Reliability criterion because of concerns about the size of the plan and the mix of plans in terms of payer source. Specifically, concern was expressed that Medicaid will probably yield more viable results; however, a small plan will be challenged to produce a report that is statistically significant and comparable. Committee members also expressed concerns about the consistency of the measure specifications with the evidence. Specifically, the goal of the measure is to assess inappropriate prescribing of antipsychotic medication to children and adolescents, however, the specifications do not measure inappropriate prescribing of antipsychotic medications but use two or more as a proxy. Overall, the Committee felt that the measure did not get to the specificity of the individual practitioner's problem with prescribing and did not adequately address situations for which it would be appropriate to prescribe more than one antipsychotic concurrently. The measure did not pass Validity (H-0; M-6; L-15; I-3) at the in-person meeting.

Developer Rationale for Reconsideration:

The developer provided a memo that summarizes their request for reconsideration and their testing results. It also noted additional information on the construct validity, based on first-year HEDIS results, had not been available for inclusion in the main submission (it was submitted later as a supplement). The developer also provided a report from the Office of the Inspector General (IG) (included in the memo) that examines the concordance of claims-based quality concerns with chart review findings; the developer notes the IG report examined the concordance of claims-based quality concerns with chart review finding, which it noted one Committee member had felt would be useful to demonstrate polypharmacy was related to poor practice and would help to further demonstrate validity.[1] Finally, the developer provided a bulletin from CMS indicating the measure is included in the 2016 CHIP Core Measure Set.

Comments Received:

Both comments received on this measure supported the Committee’s decision not to recommend the measure. One comment also encouraged the Committee to further discuss “whether using quantity as a proxy to assess safe and judicious use of a service or treatment, in this case prescribed medications, is in of itself an incorrect measurement approach.” The other comment noted a number of issues with the measure as specified, including the difficulties of using this measure for children in foster care; the difficulty finding psychiatrists for children on Medicaid; and medication changes that may incorrectly appear to be multiple concurrent medication usage.

Developer Response:

Thank you for your comment. This state- and health-plan level measure is specifically constructed to assess potentially inappropriate *long-term* concurrent use of antipsychotics. To be eligible for the measure a child must have at least 90 days of continuous use of a dispensed antipsychotic. If a medication is discontinued after 1 week and the child is started on a different antipsychotic as described in your example, the child will not be numerator compliant. Further, the numerator includes a requirement of a full 90 days of concurrent antipsychotic use in order to sufficiently allow for switching between medications and appropriate titrations between medications.

We appreciate the complexities around prescribing antipsychotics for children and adolescents.

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[1] NQF staff reviewed the report, which finds that 67% of claims (n=687) had quality problems. Of those, 37% were “too many drugs”—i.e., ~25% of claims had polypharmacy issues. The IG report defined “too many” as three or more psychotropic drugs, one of which was a second-generation anti-psychotic drug. The measure specifies two or more drugs.

This measure was reviewed by several multistakeholder advisory panels which included representatives from Medicaid, primary care clinicians and child psychiatrists. We also presented the measure to a Foster Care Measurement Advisory Panel, which specifically reviewed the measure with the perspective of improving care for foster care children. Each of our panels concluded the measure as specified had good face validity to address the issue of multiple concurrent antipsychotic use in children.

> **Action Item:** After reviewing the information provided by the developer and the comments on the Committee's recommendation, would the Committee like to reconsider this measure? Greater than 60% of the Committee must vote yes to reconsider. If the Committee agrees to reconsider, the Committee will revote on Validity, and then vote on Feasibility, Use & Usability, and Overall Recommendation for Endorsement.

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department Seattle Children's Research Institute

For 2806: *Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department* (Seattle Children's Research Institute), the Committee specifically requested that the developer bring back the measure with the age cohort limited to the older population.

This measure did not pass Validity (H-0; M-9; L-15; I-0) at the in-person meeting, in part because of concerns about the age range included in the measure; the Committee offered to reconsider it if the developer could revise the age range. Because the developer had indicated during the discussion it could make this change, the Committee discussed and voted on the remaining criteria, as well as an overall recommendation for endorsement. The Committee voted not to recommend the measure (Y-6; N-18) with the submitted age range.

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 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.

Comment 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."

> **Action Item:** After reviewing the request for reconsideration and the supporting materials, as well as the comment received, would the Committee like to reconsider 2806? Greater than 60% of the Committee must vote yes to reconsider. If the Committee agrees to reconsider, the Committee will revote on Validity and Overall Recommendation for Endorsement.