NATIONAL QUALITY FORUM

Memo

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: NQF-Endorsed Measures for Pediatric Performance

DA: June 12, 2017

Background

Approximately 74 million children under 18 years of age live in the United States, representing 23.3 percent of the population.[i] The number of children and adolescents diagnosed with chronic medical conditions has risen consistently over the last decades.[ii] In 2011-2012, 19.8 percent of these children had a special healthcare need, defined as having a chronic medical, behavioral, or developmental condition lasting 12 months or longer and experiencing a service-related or functional consequence (including the need for or use of prescription medications and/or specialized therapies).[iii] In 2012, approximately one in five adolescents had a mental disorder, increasing risk for difficulties with school, substance use, and development of chronic illnesses in adulthood.

Understanding the health-related needs of children and adolescents is essential for developing measures to improve the quality of care for the pediatric population. Currently, the NQF portfolio includes 117 NQF-endorsed measures that include the pediatric population: There are 55 NQF-endorsed measures specific to the pediatric population and 62 NQF-endorsed measures including the pediatric and adult population. The measures pertain to a range of clinical and crosscutting areas, including cardiovascular surgery, pulmonary care, cancer, perinatal care, health and well-being, and safety. Currently, many of these measures are used in public and/or private accountability and quality improvement programs, such as the Center for Medicare and Medicaid Services (CMS) Child Core Set.

For this project, the 23-member Standing Committee evaluated 11 newly submitted measures against NQF's standard evaluation criteria. The Committee recommended four measures for endorsement and did not recommend seven measures.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the Committee's 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 January 23, 2017 to February 6, 2017, for the 12 measures[1] then under review. No pre-evaluation comments were received during this comment period.

Post-evaluation comments

The draft report was posted for member and public comment from April 11, 2017 to May 11, 2017. NQF received 11 comments from four member organizations:

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

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

The Committee reviewed and responded to all comments received. Revisions to the draft report and the accompanying measure evaluation summaries are identified as red-lined changes. (Note: Typographical errors and grammatical changes have not been red-lined, to assist in reading.)

Summary of Comments and Their Disposition

Two major themes were identified in the post-evaluation comments, as follow:

1. Support for Committee recommendations
2. Gaps for future measure development

In addition, one measure, *#3136: GAPPS: Rate of preventable adverse events per 1,000 patient-days among pediatric inpatients*, received specific comments requiring a developer response and Committee discussion.

Theme 1 - Support for Committee recommendations

Five comments offered support for the Committee's endorsement recommendations, both for decisions to recommend endorsement and not to recommend endorsement. These comments provided support for the Committee's recommendations on measures #3153, #3166, #3220, and #3221. Commenters agreed with the Committee's decision not to recommend *#3220: Ask About Parental Concerns* and *#3221: Family Centered Care*, noting that despite the clear importance of these topics, there is "difficulty in attributing outcomes within these areas to specific providers and experiences." Two commenters supported the Committee's decision to recommend *#3166: Antibiotic Prophylaxis Among Children with Sickle Cell Anemia*, and one commenter supported the Committee's recommendation to endorse measure *#3153: Continuity of Primary Care for Children with Medical Complexity*.

[1] A developer withdrew one measure before the Committee's review, so the final number of measures in the project is 11.

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Committee Response: Thank you for providing these comments.

Theme 2 – Gaps for future measure development

Commenters identified several measure gap areas for consideration by the Committee. Specifically, they suggested gaps could be addressed by the following clinic-/system-level measure concepts:

- The identification of a team to work together to plan and test improvements in providers' ability to elicit parental strengths and needs within a practice site.
- Defining parental strengths and needs within a practice site.
- Integrating tools such as process flows, prompts, and reminders into practice flow to support the engagement of parents.
- Clinic-/systems-level measures that offer more specificity about appropriate antibiotic prophylaxis in children with sickle cell anemia.

Committee Response: Thank you for providing this comment. These gaps have been added to the measure gaps list.

Measure-Specific Comments

#3136: GAPPS: Rate of preventable adverse events per 1,000 patient-days among pediatric inpatients

Two comments focused on measure *#3136: GAPPS: Rate of preventable adverse events per 1,000 patient-days among pediatric inpatients*. The developer has addressed each concern separately.

The American Academy of Pediatrics submitted questions and suggested updates intended to clarify automated triggers to increase the specificity and clarity of the measure specifications.

Developer Response to the Academy of Pediatrics:

- Trigger: Consider rewording to "Hepatotoxic medications and RISING liver enzymes (AST, ALT)"

  Thank you for the suggestion. A consideration here is that if there were not previous hepatic enzyme measurements and the first measurement showed elevated enzymes, this would need to be investigated. If this were written to only include those that are rising (therefore requiring a previous lower value), the process might miss a possible hepatoxic injury. Therefore our preference is to retain the language as "elevated."

- Please explain how "Physician orders: Abrupt medication stop" is defined in the automated trigger tool? Most medication stops are abrupt (with rare exceptions like steroid weans or PCA infusions)

  The definition in our Manual of Operations reads as follows, "An abrupt medication stop is best described as an unexpected stop or deviation from typical ordering practice (e.g., discontinuation of a recently started medication)." Since this type of clinical decision making may be challenging to automate, it is not recommended for electronic trigger review.

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- Please define “Transfer to higher level of care” more specifically. Many hospitals have observation units where most patients go home but some patients are admitted to the floor (higher level of care) after a specified time.

  The definition from our Manual of Operations reads as follows, “All transfers from an acute care area to an intensive care unit or intermediate care unit (“step-up unit”) should be considered a trigger.” Therefore the scenario presented in the comment would not meet the defined criteria.

- Consider changing Pressure ulcer documentation to “>= Stage 2” instead of just stage 2.

  Thank you for identifying this discrepancy. This was a typographical error and should read as you suggest. During our testing, the reviewers were instructed to investigate exactly as is suggested by the comment, meaning all pressure injuries Stage 2 and higher and unstageable. We will edit the relevant documents to reflect this change.

- Many places will start patients on laxatives simultaneously with opioids, but patients will still get constipated. Would this qualify as a trigger, or is it only a trigger if laxatives are started after (e.g. >=24 hours after) opioids are started? Latter would be more specific, less sensitive.

  Thank you for pointing out this ambiguity. We agree that excluding cases where laxatives are introduced concurrently (<24 hours after) with opioids is reasonable. The trigger is looking at cases where laxatives were given subsequent to the initial prescription of opioids (>=24 hours after). We will edit the relevant documents to reflect this change.

- Consider adding “positive coagulase-negative staphylococcus species blood culture” as a trigger for review; per algorithm, it should have a higher than 10% rate of being a true contaminant (i.e., an adverse event).

  Thank you for this comment. Since we currently look at a more broadly based trigger (positive blood culture 48 hours after admission), all of the occurrences of the suggested trigger would be included in the trigger as written. We hesitate to insert a new trigger into the recently reviewed tool at this stage.

- Please clarify the denominator of whether a partial day counts as a day. For example, is 1.5 days = 2 days or 1.5 days? What is the start and stop time for determining LOS duration (e.g. start of: time of arrival to floor, time of admission from ED; end of: time of discharge order, time of leaving hospital?)

  Length of stay is calculated as the number of days (discharge date minus admit date). For example, a patient who arrives at 4am on May 17th and is discharged at 4pm on May 18th has a length of stay of 1.0 day. However, a patient who arrives at 10pm on May 17th and is discharged at 10am on May 19th has a length of stay of 2.0 days. Start and stop times were not used to determine length of stay duration, only admit and discharge date.

- Step 2: Line 4. Please describe whether the unit of study (whether entire hospital, division, etc.) should remain stable over time.

  Thank you for the opportunity to clarify. We would suggest that the unit of interest remain stable over time.

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One commenter did not support the endorsement of this measure. The commenter noted that implementing the trigger tool might be difficult and require excessive resources, and suggested that the tool lacks validity in identifying adverse events.

Developer Response to Dr. Austin of Armstrong Institute for Patient Safety and Quality at Johns Hopkins University:

We would like to thank Dr. Austin for his comments. As the measure is implemented, the resource burden, while not trivial, should be manageable while providing a great deal of benefit in terms of increased safety events identified. The primary reviewer, typically an experienced nurse, is asked to perform chart review quarterly on 60 patient records per quarter with a limit of 30 minutes per chart. This would represent a total of 30 hours per quarter or 10 hours per month or 2.5 hours a week. The secondary reviewer, typically a physician, reviews the primary reviewer's findings. Assuming a high rate of harm or 33 events per 100 admissions, this would be 20 events to review each quarter. During validation testing, our physician team required on average 4 minutes per chart to review. Therefore, the typical time burden on the secondary reviewer would be approximately 80 minutes per quarter. Based on the frequency of events and the resources required, it is our view that the benefit of this modest resource requirement would far outweigh the burden.

In regards to validity, we developed the draft trigger tool used in the GAPPS measure through the RAND/UCLA Appropriateness Method, which is a modified Delphi process.(1–3) We first compiled a set of 78 candidate triggers from a literature review of existing pediatric and adult trigger tools and input from trigger tool experts.(4–6) We then recruited nine panelists from national pediatric and patient safety organizations and asked them to rate separately the validity and feasibility of the candidate triggers on a nine-point scale (where 1 is the least valid/feasible and 9 is the most valid/feasible). A trigger was considered valid if it was judged to be reasonably likely to identify an underlying AE, indicating that harm potentially occurred. A trigger was considered feasible if it was judged likely to be accurately and consistently documented in either paper or electronic medical records as part of patient care at a wide range of hospitals, from smaller community sites to larger tertiary care centers. Applying the RAND/UCLA Appropriateness Method, we accepted triggers that had both median validity and feasibility ratings greater than or equal to seven. This approach resulted in inclusion of 54 of the initial 78 candidate triggers in the draft GAPPS trigger list.

We focused our validity testing on evaluation of how accurately and completely "typical reviewers" (i.e., clinicians who are trained in GAPPS methodology but not necessarily trigger tool experts) were able to identify preventable AEs using the measure as compared to expert reviewers. The expert reviewers had extensive experience with using trigger tools for preventable AE identification and consequently were most likely to identify preventable AEs accurately and completely. To evaluate the validity of the GAPPS measure, we assessed the performance of the National Field Test hospitals' internal reviewers relative to the performance of external expert reviewers in applying the measure (as documented in our NQF submission materials).

REFERENCES

1. Fitch K, Bernstein S, Aguilar MD, Burnand B, LaCalle JR, Lázaro P, et al. The RAND/UCLA Appropriateness Method User's Manual. Santa Monica, CA: RAND; 2001.

Please note that voting concludes on June 26, 2017 at 6:00 pm ET – no exceptions.

2. Brown B. DELPHI PROCESS: A Methodology Used for the Elicitation of Opinions of Experts. Rand Corp. 1968 Sep;1–14.

3. Sweidan M, Williamson M, Reeve JF, Harvey K, O'Neill JA, Schattner P, et al. Identification of features of electronic prescribing systems to support quality and safety in primary care using a modified Delphi process. BMC Med Inform Decis Mak. 2010 Apr 15;10(1):21.

4. Stockwell D, Bisarya H, Classen D, Kirkendall E, Landrigan C, Lemon V, et al. A trigger tool to detect harm in pediatric inpatient settings. Pediatrics. 2015;

5. Griffin FA, Resar RK. IHI Global Trigger Tool for Measuring Adverse Events (Second Edition). Institute for Healthcare Improvement; 2009. (IHI Innovation Series white paper).

6. Kirkendall ES, Kloppenborg E, Papp J, White D, Frese C, Hacker D, et al. Measuring adverse events and levels of harm in pediatric inpatients with the Global Trigger Tool. Pediatrics. 2012 Nov;130(5):e1206-1214.

Committee Response:

Thank you for providing these comments on measure #3136. The Committee discussed the measure specifications and validity during the in-person meeting. The Committee did note that that the highest possible score for reliability was a moderate, since the measure is tested at the data-element level only; the highest possible score for validity also is moderate, since validity testing is patient-level data element. Overall, the Committee determined that the measure as specified and tested offered sufficient validity for endorsement and did not wish to reconsider the measure.

Meeting Follow-Up Issues

Consensus Not Reached

3154: Informed Coverage

During the in-person meeting, Committee members agreed this was an important outcome to assess, but they were concerned about the measure's ability to discern differences among states due to the overlap of the 95% confidence intervals of the performance scores provided for score-level reliability testing. The Committee believed that the measure would be a useful self-assessment tool for states to improve their coverage rates, but questioned whether this measure could be used for accountability purposes. The Committee did not reach consensus on Reliability (1-H; 11-M; 9-L; 3-I).

A memo from the developer responding to the issue of overlap, as well as other questions brought up by the Committee during the in-person meeting, was provided to the Committee prior to the post-comment call and is provided in Appendix A of this memo. With respect to the issue of the overlapping performance scores, the developer summarized the graph (previously provided) as follows:

- 24 of 43 states (55.8%) can be distinguished from more than 1/2 of the other states;
- 11 (25.6%) states can be distinguished from more than 2/3 of the other states;
- At each end of the spectrum (high and low performers), 3 of 43 states (7.0%) and 3 of 43 states (7.0%), respectively, can be distinguished from 3/4 of the other states.

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One NQF member, the American Academy of Pediatrics (AAP), commented on #3154. AAP agrees with the intent of the measure to more accurately capture the continuity of coverage in the Medicaid program, but recommends that this measure be further validated and re-evaluated for endorsement in the future.

Developer Response:

We appreciate that the AAP agrees with the intent of our measure to more accurately capture the continuity of coverage in the Medicaid program so that states can improve coverage. The AAP suggested that our measure "requires assumptions that may not be universally accepted," without telling us which assumptions are objectionable. We would point out that with our assumptions, our results were carefully validated against the gold standard ACS (American Community Survey). Our results, in both development and validation, were superior to the current metrics of Continuity Ratio (Ku et al.) and Duration (currently used by CMS). Informed Coverage had better correlation with the ACS and less error deviation than the other metrics. See Validity Testing, Section 2b2.3, Table 2: Pearson Correlations. Also, see Validity Testing, Section 2b2.3, Table 3: Median Absolute Errors.

Committee Response:

During the call, Committee members discussed their previous concerns about children who were on the cusp of income eligibility. The developer explained that while it did not have access to the incomes of individuals, an analyses was conducted using the average income on a state level. The developer noted that analyses showed that the metric is stable across income levels across states. The developer noted that rates of reenrollment are largely policy-driven (i.e., how easy or difficult it is to reenroll) rather than by income, and that improvements in performance can be made by making it easier to re-enroll.

Also during the post-comment call, a Committee member inquired about the intended use of the measure. The developer noted that this could be used by states to measure improvement after implementing initiatives. The measure also helps to identify states that report rates much lower or much higher than other states for closer examination.

Currently, the measure relies on presumptive eligibility for Medicaid; the Committee and developer agreed that if eligibility changes, the measure would need revision.

After its discussion, the Committee re-voted on the Reliability criterion, which had not achieved consensus during the in-person meeting; the measure passed this criterion.

Following that vote, Committee members briefly discussed unintended consequences should the measure be used for rewards or penalties; but ultimately agreed this measure is no different than any other measure that has intrinsic errors, and that as long as the range of error is clearly defined, the measure can be useful. The Committee voted on an overall recommendation for endorsement, and agreed the measure should be recommended.

Requests for Re-consideration

3189: Rate of Emergency Department Visit Use for Children Managed for Identifiable Asthma: Visits per 100 Child-years

During the in-person meeting, the Committee concluded that the testing information was insufficient to meet NQF's minimum standards, and the measure did not pass Reliability (N/A-H; 1-M; 4-L; 18-I). No comments were received specific to this measure during the post-meeting commenting period.

The developer submitted a request for reconsideration of #3189. A brief summary of the request for reconsideration follows, and a memo from the developer outlining in detail why the measure should be reconsidered and what changes have been made since the last review are included in Appendix B.

Developer Rationale for Reconsideration:

"At the in-person meeting, measure #3189 passed on Evidence and Gap, and was voted insufficient for Reliability. In general, the sense of the group [the Committee] at the in-person meeting was that measure #3189 is a very viable measure, but having to conform to the NQF procedure, the group required a little bit more data, which is provided herein:

1) Reliability
2) Inclusion/Exclusion
3) Pharmacy Data
4) Race Disparities
5) Data Element Validity"

Committee Response:

The Committee reviewed the new materials prior to the call, and after discussion on the call, agreed that the new information was not sufficient to address its concerns about Reliability. The Committee voted not to reconsider the measure.

2816: Appropriateness of Emergency Department Visits for Children and Adolescents with Identifiable Asthma

During the in-person meeting, the Committee raised a number of significant concerns with the testing and construction of the measure and the appropriateness criteria. Specifically, the measure was tested in only one hospital, making it difficult to discern meaningful differences among institutions, and not all critical data elements related to appropriateness were tested. The Committee also noted that the measure specifications permit variable use of pharmacy data, as available. Measure #2816 did not achieve consensus on Evidence (12-Pass; 10-No Pass) and did not pass Validity (N/A-H; 1-M; 17-L; 5-I); therefore it was not recommended for endorsement. The developer used data element level validity testing, which is accepted under NQF guidance to assess both Reliability and Validity; therefore, the Committee did not vote separately on Reliability.

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One comment was received for this measure from the American Academy of Allergy, Asthma and Immunology (AAAI), which supported concerns about the lack of risk adjustment brought up by the NQF Pulmonary and Critical Care Standing Committee during a previous review; the Pediatric Committee did not discuss this issue since the discussion did not progress to that aspect of validity, given the other concerns. A summary of the request for reconsideration is below, and a memo from the developer outlining in detail why the measure should be reconsidered and what changes have been made since the last review are included in Appendix B.

Developer Rationale for Reconsideration:

At the in person meeting, for measure #2816, consensus was not reached for Evidence, the measure passed on Gap, and did not pass on Reliability. While the developer has requested reconsideration for both measures, they did not provide a separate, specific rationale for this measure. The developer noted that the data provided for #3819 also informs this measure; no additional information was provided specifically related to appropriateness. The updated data are included with the information on #3189 begins on page 17 of Appendix B.

Developer Response to Comment:

"We have submitted this to the Pediatric Committee in part because of its greater sensitivities to the issues specific to children and in this case asthma in children. Nearly half of US children are covered by public health insurance programs. Equity of outcomes across race and social class is a preeminent concern and value in child health, especially for asthma. As the internationally accepted NHLBI guidelines states, "As a general rule, patients with well-controlled asthma should have:

- Few, if any, asthma symptoms.
- Few, if any, awakenings during the night caused by asthma symptoms.
- No need to take time off from school or work due to asthma.
- Few or no limits on full participation in physical activities.
- No emergency department visits.
- No hospital stays.
- Few or no side effects from asthma medicines."

Further it is not clear whether those stressors that increase asthma burden are likely to increase or to decrease the level of appropriateness of ED use for asthma. Cogent arguments can be made in either direction, or for not at all.

Measure 2816, Appropriateness of Emergency Department Visits for Children and Adolescents with Identifiable Asthma, is stratified by age, specifically the measure is reported for children ages 2-5,6-11, 12-18, and optionally, 19-21. This is because asthma and its management are related both to the child's age and stage of development. Hence comparing performance in young children is very different from performance in adolescents.

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Further, this measure of appropriateness is best interpreted in light of other measures, such as the rate of ED use for asthma. High levels of appropriateness may suggest a highly functional primary care and outpatient approach to asthma. However high levels of appropriateness and high levels of utilization may together suggest that asthma outcomes form outpatient management are not as desired. Hence, this measure informs but is not dispositive without other data.

Our formal RAND style panel of national experts did not recommend risk adjustment by race or social class. They recommend stratification by the age groups indicated below. Environmental differences may produce unequal burdens on various health plans, but the field's capacity to discriminate and risk adjust in that manner is of uncertain value and such data for adjustment are neither readily available, nor is there a consensus on what and when and how to adjust for such exposure.

Establishment of asthma control should occur from an early age. Because of challenges in identifying asthma before the age of 2, we have not included this age group in our specification.

For purchasers who are interested in stratification beyond race and age we provide OPTIONAL specifications that allow them to ask health plans to incorporate additional stratification in the measure (e.g. insurance status, county rates of poverty, and rurality/urbanicity). Contracting health plans can negotiate with purchasers and other accountability agencies to demonstrate stratified performance if they so desire.

This measure requires stratification by the following age groups:

- Age 2-5 years (second birthday to the day before the 6th birthday);
- Age 6-11 years (sixth birthday to the day before the 12th birthday);
- Age 12-18 years (twelfth birthday to the day before the 18th birthday); and
- Age 19-21 years (nineteenth birthday to the day before the 21st birthday).

These age strata are to be reported distinctly and not combined for reasons noted above.

This measure has optional stratifications for the following that can be determined by the reporting agency to use all or none, as appropriate:

- Race/Ethnicity: Hispanic, Non-Hispanic Black, Non-Hispanic White; Non- Hispanic Asian/Pacific Islander, other Non-Hispanic
- Insurance type (Public, Commercial, Uninsured)
- Benefit type (if insured): HMO, PPO, Medicaid Primary Care Case Management (PCCM) Plan, Fee for Service (FFS), other relevant enrollment categories (e.g., TANF, SSI)
- Urban influence codes: Identify the Urban Influence Code or UIC. (2013 urban influence codes available at: http://www.ers.usda.gov/data-products/urban- influence-codes.aspx#.UZUvG2cVoj8). Use parent or primary caregiver's place of residence to determine UIC. State and county names can be linked or looked up directly or zip codes

can be linked to county indirectly, using the Missouri Census Data Center (http://mcdc.missouri.edu/). These data will link to county or county equivalents as used in various states.
- Urban Influence Codes (UIC) have been developed by the USDA to describe levels of urbanicity and rurality. While each UIC has its own meaningful definition, some researchers choose to aggregate various codes. Well regarded schemas for aggregation of codes include Bennett and colleagues at the South Carolina Rural Research Center. Their aggregation scheme brings together Codes 1 & 2 as Urban; 3,5, & 8 as micropolitan rural; 4,6, & 7 as rural adjacent to a metro area; and 9, 10, 11, & 12 as remote rural. We acknowledge that UIC 5 (adjacent rural area) may appropriately be aggregated with 4,6,&7 as rural. Frontier health care may be approximated by analysis of the remote rural categories (UIC 9, 11 and 12). Alternatively, Gary Hart, Director of the Center for Rural Health at the University of North Dakota School of Medicine & Health Science suggests that UIC 9-12 is the best overall approach to using county level data to study frontier health. Inclusion of UIC 8 would make the analysis more sensitive to including frontier areas but at a meaningful cost in specificity.
- Those interested in care specific to large cities may wish to aggregate the rural area and analyze UIC 1 and 2 separately.
- When stratifying by urbanicity or UIC, the reporting and accountability entities should specify clearly what if any aggregating schema was used.
- Identify the Level of Poverty in the parent or primary caregiver's county of residence. The percent of all residents in poverty by county or county equivalent are available from the US Department of Agriculture at http://www.ers.usda.gov/data-products/county-level-data-sets/download- data.aspx. Our stratification standards are based on 2011 US population data that we have analyzed with SAS 9.3. Using parent or primary caregiver's state and county of residence (or equivalent) or FIPS code, use the variable PCTPOVALL_2011 to categorize into one of 5 Strata:
 o Lowest Quartile of Poverty if percent in poverty is <=12.5%
 o Second Quartile of Poverty if percent in poverty is >12.5% and <=16.5%
 o Third Quartile of poverty if percent in poverty is >16.5% and <=20.7%
 o First Upper Quartile (75th-90th) if percent in poverty is >20.7% and <=25.7%
 o Second Upper Quartile (>90th percentile)

These classification standards may be updated by the accountability entity using more recent data if desired.

To summarize:

Appropriateness of ED visits is a new construct for pediatric asthma. As such, there are no pre-existing data to suggest a disparate burden of either appropriate or inappropriate ED visits by socioeconomic class or by health plans caring for them. The NHLBI guideline is clear in articulating the expectation that outcomes should be equally good across the general population of individuals regardless of who they are and even how severe their asthma is (obviously there are true exceptions here, but they would not be well accounted for in any risk adjustment or stratification schema that we have ever seen). The Pediatric Committee is in a better position to understand and appreciate

the implications of all of this for children and to incorporate such insights into their evaluation of this measure (and the similar rate measure).

The lack of required stratifications by risk does not lead to misinterpretation of results as a potential unintended consequence if the measure is implemented. In fact, this measure is specified to give flexibility to plans and to purchasers to respond to local conditions and needs by using stratification as needed and desired to compare performance within specified strata. These are desirable attributes for child health quality measures."

Committee Response:

The Committee reviewed the new material prior to the call, and after discussion, agreed that the new information was not sufficient to reconsider the measure. Specifically, the Committee agreed the new information did not address the issues raised previously with the validity of the numerator construct (i.e., the measure was still only tested at one institution); the Committee also agreed its concerns about the evidence were not adequately addressed. The Committee voted not to reconsider the measure.

NQF Member Voting

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

Please note that voting concludes on June 26, 2017 at 6:00 pm ET – no exceptions.

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[i] Colby, Sandra L., and Jennifer M. Ortman. "Projections of the size and composition of the US population: 2014 to 2060." *Current Population Reports* P25-1143 (2015).
[ii] McGrady, Meghan E., and Kevin A. Hommel. "Medication adherence and health care utilization in pediatric chronic illness: a systematic review." *Pediatrics* 132.4 (2013): 730-740.
[iii] HRSA, MCHB. *Child Health USA 2014*. Rockville, MD: HHS; 2015. Available at http://mchb.hrsa.gov/chusa14/. Last accessed December 2015.

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