Prevention and Population Health, Fall 2018 Cycle: CDP Report

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Prevention and Population Health, Fall 2018 Cycle

Executive Summary

Traditionally, efforts to improve the health and well-being of individuals and populations have focused on medical care. As a result, the majority of national healthcare spending has been attributed to healthcare services. However, it is well known that the impact of medical care on health is relatively low, especially when compared to intervention-based health prevention, such as smoking cessation programs, and social determinants of health (SDOH), such as educational level, poverty, poor diet, and physical environmental hazards (e.g., unsafe housing and polluted air). Accordingly, the influence of SDOH on health outcomes should be considered and measured in tandem with medical care and healthcare services. A multidisciplinary and multifactorial approach to address SDOH is necessary for maintaining and improving the health and well-being of individuals and populations at large.

Just as measures have been developed for medical care, performance measures are needed to assess improvements in population health, as well as the extent to which healthcare stakeholders are using evidence-based strategies (e.g., prevention programs, screening, and community needs assessments). To support this effort, the National Quality Forum (NQF) endorses and maintains performance measures related to prevention and population health through a multistakeholder consensus development process.

Although this project focused on measure endorsement, NQF's work includes additional efforts on population health and prevention that provide context for and supplement this measure endorsement work, including efforts to reduce disparities in health outcomes and promote the coordination of care in communities to improve local population health. For example, NQF commissioned a report to identify opportunities to align health improvement activities and measurement across the healthcare and government public health systems. Most recently, NQF developed an action guide that provides practical guidance for communities to make lasting improvements in population health.

NQF's prevention and population health portfolio of measures includes measures for health-related behaviors to promote healthy living; community-level indicators of health and disease; social, economic, and environmental determinants of health; primary prevention and/or screening; and oral health (see Appendix B).

For the fall 2018 cycle, the Prevention and Population Health Standing Committee evaluated three previously endorsed measures undergoing maintenance review against NQF's standard evaluation criteria, and the Consensus Standards Approval Committee (CSAC) upheld the Committee's continued endorsement recommendation. The endorsed measures are:

- 1392 Well-Child Visits in the First 15 Months of Life (National Committee for Quality Assurance)
- 1407 Immunizations for Adolescents (National Committee for Quality Assurance)
- 1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (National Committee for Quality Assurance)

This report summarizes the evaluated measures; Appendix A provides detailed summaries of the Committee's discussion and ratings of the criteria for each measure.

Introduction

The United States continues to lag behind other nations in key population health indicators such as infant mortality, obesity, and life expectancy, despite spending more on healthcare than any other nation in the world.[1] Population health describes the "health outcomes of a group of individuals, including the distribution of such outcomes within the group."[2] Both medical care and SDOH influence health outcomes. SDOH includes factors such as availability of safe housing and local food markets, access to healthcare services, and culture. Nearly 60 percent of deaths in the United States have been attributed to SDOH,[3] yet less than 5 percent of national health expenditures have been attributed to prevention services.[4] Furthermore, healthcare systems are increasingly expanding their roles to collaborate with patients and communities to better address SDOH.

Performance measurement is necessary to assess whether healthcare stakeholders are using strategies to increase prevention and improve population health. Strengthening measurement of prevention and population health will require joint efforts from communities, public health entities, and other nonhealthcare stakeholders (e.g., education, transportation, and employment) that influence health outcomes. Growing evidence demonstrates that targeted programs and policies can prevent disease, increase productivity, and yield billions of dollars in savings for the U.S. healthcare system. The United States can reduce the incidence of morbidity and premature mortality by identifying the right measures and implementing evidence-based interventions.

To support this goal, the NQF maintains a portfolio of measures endorsed through a multistakeholder consensus development process and has developed best practices for prevention and population health. NQF's prevention and population health portfolio includes measures that assess the promotion of healthy behaviors, community-level indicators of health, oral health, and primary prevention strategies. For example, NQF has endorsed several measures related to immunizations and screenings that are widely used in public reporting and accountability programs.

This project seeks to identify and endorse measures that can be used to assess prevention and population health in both healthcare and community settings. It also focuses on the assessment of disparities in health outcomes. The measures reviewed during the fall 2018 cycle focused on childhood immunizations and well-child visits. These measures promote population health and lower morbidity and cost over an individual's lifetime.

NQF Portfolio of Performance Measures for Prevention and Population Health

The Prevention and Population Health Standing Committee (Appendix C) oversees the vast majority of NQF's portfolio of population health measures (Appendix B), which includes measures for immunization, pediatric dentistry, and weight/BMI among others. The Committee's portfolio contains 36 measures: 25 process measures and 11 outcome measures (see Table 1).

Table 1. NQF Prevention and Population Health Portfolio of Measures

	Process	Outcome/Resource Use
Immunization	10	0
Pediatric Dentistry	4	1
Weight/BMI	3	0
Diabetes-Related	0	4
Admission Rates	0	5
Cancer Screening	4	0
Cardiovascular Pulmonary	1	1
Colonoscopy	1	0
Well-Child Visits	2	0
Total	25	11

Some measures related to prevention and population health are assigned to other project committees. These include various diabetes assessment and screening measures (Behavioral Health project), HIV viral load (Primary Care and Chronic Illness project), Angiotensin-converting enzyme inhibitor/Angiotensin II receptor blockers (ACEI/ARB) medication measures (Cardiovascular project), perinatal immunization and screening (Perinatal and Women's Health project), gastrointestinal and asthma admission rates (All-Cause Admissions and Readmissions project), and one cost and resource use measure (Cost and Efficiency project).

Measure Evaluation

On February 7, 2019, the Prevention and Population Health Standing Committee evaluated three measures undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Prevention and Population Health Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	3	–	3
Measures endorsed	3	–	3
Measure withdrawn from consideration	1	–	1
Reasons for not recommending	Importance – N/A Scientific Acceptability – N/A Use – N/A Overall Suitability – N/A Competing Measure – N/A	Importance – N/A Scientific Acceptability – N/A Overall Suitability – N/A Competing Measure – N/A	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the

commenting period opened on December 11, 2018, and closed on April 19, 2019. No comments were submitted.

Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 19, 2019. Following the Committee's evaluation of the measures under consideration, NQF did not receive any comments pertaining to the draft report or to the measures under review.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Committee's recommendations. NQF did not receive any feedback on the submitted measures.

Overarching Issues

During the Standing Committee's discussion of the measures, two overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Feasibility Challenges of Measure Implementation

For each of the measures reviewed for maintenance of endorsement, the Committee questioned the overall feasibility of the metric. For the two measures related to well-child visits, the issue of most concern for the Committee related to abstraction from paper charts. The Committee also noted that as the United States increasingly moves from paper charts to electronic medical records, the feasibility issue for these two measures will resolve. Nonetheless, the Committee requested that the measure developer investigate the issue and report back in the next maintenance review.

The issue related to feasibility for the adolescent immunization status measure centered on the addition of the human papilloma virus (HPV) vaccine to the composite score. Some Committee members noted that health plans may find it challenging to ensure that patients receive the HPV vaccine series before the age of 13 given longer time horizons for completion based on current guidelines. According to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), the upper limit for receipt of HPV vaccine is 15 years of age for the two-dose schedule. The Committee expressed concern about the measure's specifications for HPV, which require that the vaccination series be completed by age 13. The Committee accepted the measure developer's explanation that ACIP recommends vaccination as early as age 9 for HPV vaccine, and ACIP also expressed a strong preference for the completion of the series early.

More Thorough Review of Social Determinants of Health

For each of the measures, the Committee called for the measure developer to conduct a more thorough assessment of the impact of SDOH. The Committee noted that familial factors play a key role in determining whether a child would be likely to present for well-child visits. A comparable discussion occurred when variance in vaccine administration was assessed when stratifying by race/ethnicity. The

Committee expressed concern that there are clear social inequities that influence performance on these measures, and the developer must discuss them in more detail in the next maintenance review.

Summary of Measure Evaluations

The following brief summaries of the individual measure evaluations highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Well-Child Visit Measures

1392 Well-Child Visits in the First 15 Months of Life (National Committee for Quality Assurance): Endorsed

Description: Percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. Overall, the Committee did not express concerns about evidence, reliability, or validity of the measure. The Committee acknowledged a performance gap and opportunity for improvement, as evident through disparities in performance between commercial insurance and Medicaid plans. The Committee noted that the measure is calculated through data elements captured during routine care and are available in electronic form; however, as noted in the section on overarching issues, the Committee expressed concerns about feasibility, and asked that the developer re-assess the paper chart review at the measure's next maintenance review cycle. As with NQF 1516, the Committee recommended that the developer include SDOH-related questions in the measure and that insurers take a more active role in using the measure results to increase access to healthcare for children. The Committee noted that this measure overlaps with the perinatal assessment of postpartum depression for new mothers during the six-month well-child visit. For future iterations of the measure, the Committee stated that it would be beneficial for the developer to look at family-level assessments within the context of the whole family with a focus on maternal health and wellness post-partum, especially with regards to SDOH.

1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (National Committee for Quality Assurance): Endorsed

Description: The percentage of children 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. The Committee stated that while the evidence does not include randomized controlled trials, this does not necessarily undercut the measure, as it still accords with the American Academy of Pediatrics' Bright Futures recommendations. The Committee noted there is disparity in performance between commercial insurance plans and Medicaid plans. The Committee did not express concerns regarding the reliability or validity of the measure. In the discussion of feasibility, the Committee noted that the measure can be

collected by either electronic medical records or paper chart review; it also noted that as the country becomes increasingly less dependent on paper records, the feasibility of this measure will continue to improve. During the next maintenance review of the measure, the Committee recommended that the developer assess whether the paper chart review is still needed, since it can increase the reporting burden.

The Committee stated that while the measure is in wide use, there has not been a notable increase in health plan performance year over year. The Committee recommended that plans move beyond collecting these data to using the data to improve healthcare access for children. Additionally, the Committee recommended that the developer focus on the content of the well-child visits in the future, rather than the mere existence of them. For instance, the Committee noted that the developer could include important SDOH as a part of the well-child visit, since SDOH, such as adverse childhood events, nutrition, domestic violence, and housing, are known to impact health. The Committee stated that this information is readily available in many cases, since numerous electronic medical records (EMRs) capture information on whether a provider asked about specific SDOHs. It asked the developer to report back on this approach during the next maintenance review.

Immunization Measure

1407 Immunizations for Adolescents (National Committee for Quality Assurance): Endorsed

Description: Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. Committee members noted that the measure is based on evidence from the Advisory Committee on Immunization Practices (ACIP) guidelines, which are endorsed by the Centers for Disease Control and Prevention. Since the Committee's last full review, Human Papilloma Virus (HPV) vaccination has been added to this measure. The Committee noted the significant variability in performance rates is largely driven by performance related to the HPV component, with less variability for the other two vaccinations included within the measure. It was noted that this does not detract from the importance of the measure, and the Committee determined that a performance gap exists. The Committee expressed concerns regarding coding and appropriate documentation of these data in its discussion of the overall validity of the measure. The feasibility discussion centered on the disparity between the measure specification requiring receipt of the HPV vaccine by age 13, and the ACIP child vaccination guidelines, which allow for later administration. Lastly, as noted in the section on overarching issues, Committee members requested that the developer provide granular disparities information during the next maintenance review.

Measure Withdrawn from Consideration

One measure previously endorsed by NOF was not re-submitted for maintenance of endorsement. Endorsement for this measure has been removed.

Table 3. Measure Withdrawn from Consideration

Measure	Reason for withdrawal
0659 Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	The developer stated that the measure is considered "topped out," meaning it no longer addresses a performance gap area.

References

[1] Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2017: OECD Indicators factsheet. Paris, France: OECD Publishing; 2017. https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf. Last accessed March 2018.

[2] Kindig D, Stoddart G. What is population health? *Am J Public Health*, 2003;93(3)380-383.

[3] Kindig DA, Asada Y, Booske B. A population health framework for setting national and state health goals. *JAMA*. 2008;299(17):2081-2083.

[4] Bipartisan Policy Center. *Lots to Lose: How America's Health and Obesity Crisis Threatens Our Economic Future*. Washington, DC: Bipartisan Policy Center; 2012.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Endorsed Measures

1392 Well-Child Visits in the First 15 Months of Life

Submission | Specifications

Description: Percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year.

Numerator Statement: Children who received six or more well-child visits with a PCP during their first 15 months of life.

Denominator Statement: Children who turn 15 months old during the measurement year.

Exclusions: This measure excludes children in hospice.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 2/7/2019

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

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

1a. Evidence: **Accepted vote from Committee's prior evaluation**; 1b. Performance Gap: **H-6**; **M-6**; **L-0**; **I-0;**

Rationale:

- This maintenance measure focuses on the percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year. The measure aligns with the updated versions of both the American Academy of Pediatrics (AAP)/Bright Futures guidelines.
- The evidence that the developer provided is directionally the same as for the previous version of the measure.
- The Committee accepted the vote from its prior evaluation on evidence.
- Performance data are summarized at the health plan level and summarized by number of plans reporting, mean, standard deviation, minimum health plan performance, maximum health plan performance, and performance at the 10th, 25th, 50th, 75th and 90th percentile including Interquartile Range. Data are stratified by year and product line (i.e., commercial and Medicaid).
- Performance has been improving across commercial product lines. The rates were 77.30% in 2014, 77.82% in 2015, and 78.41% in 2016.

- Performance has been consistently improving for Medicaid plans. The rates were 58.71% in 2014, 59.35% in 2015, and 61.70% in 2016.
- With respect to performance gap, in 2016, there was a 21-percentage point difference between commercial plans in the 10th percentile and plans in the 90th percentile and a 22-percentage point difference for Medicaid plans. These gaps in performance underscore the opportunity for improvement.
- The developer noted that Medicaid vs. commercial can be considered a proxy for social determinants of health (SDOH). The developer also provided examples from the literature on well-child visits and disparities.
- The Committee acknowledged a performance gap and opportunity for improvement, as evident through disparities in performance between commercial insurance and Medicaid plans.
- The Committee recommended that the developer include SDOH-related questions in the measure.
- The Committee noted that this measure overlaps with the perinatal assessment of postpartum depression for new mothers during the six-month well-child visit. For future iterations of the measure, the Committee stated that it would be beneficial for the developer to look at family-level assessments within the context of the whole family with a focus on maternal health and wellness post-partum, especially with regards to SDOH.

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

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

2a. Reliability: **H-4**; **M-8**; **L-0**; **I-0;** 2b. Validity: **H-1**; **M-11**; **L-0**; **I-0**

<u>Rationale</u>:

- The developer conducted empirical score-level reliability and validity testing.
- The developer provided measure score reliability using the beta-binomial method (signal to noise ratio) and the 2016 HEDIS data set of HEDIS (398 commercial plans and 204 Medicaid plans). The reliability score for commercial plans was 0.99 and the 10-90th percentile range was 0.87-1.00. For Medicaid plans, the statistics were 0.98 and 0.94-0.98, respectively. The developer concluded the measure has high reliability.
- The developer did not conduct data element level reliability testing even though multiple data sources may be used. For plans using medical record abstraction, reliability of the measure is dependent on correct abstraction of well-child visit data from health records. The developer does not offer an analysis of these data sources relative to the stability of the metric.
- The Committee agreed that the measure meets the Reliability criterion.
- The developer assessed construct validity against other HEDIS measures and face validity.
- Pearson Correlation Coefficients were calculated for three aspects of weight assessment counseling (BMI percentile, counseling for nutrition, counseling for physical activity); Children Access Primary Care Provider 12-14 months; Childhood Immunization Status—All Vaccines; Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. Correlation coefficients ranged from 0.3 to 0.7; all correlations were significant at $p<0.0001$. The developer concludes the results indicate moderate to strong positive correlation of the hypothesized associations.
- Face validity was assessed by three panels: Child Health Measurement Advisory Panel; Technical Measurement Advisory Panel; and Committee on Performance Measurement. The developer stated the panels concluded “with good agreement” that the measure is specified to accurately

assess well-child visits in health plans." No quantitative representation of agreement was provided.
- The Committee agreed the measure meets the Validity criterion.

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3. Feasibility: H-7; M-5; L-0; **I-0**

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

Rationale:

- The Committee noted that the measure is calculated through data elements captured during routine care and are available in electronic form.
- The Committee noted that this measure shares similar feasibility issues to NQF 1516, also reviewed in this project. It noted that the measure can be collected by either electronic medical records (EMRs) or paper chart review; it also noted that as the country becomes increasingly less dependent on paper records, the feasibility of this measure will continue to improve.
- During the next maintenance review of the measure, the Committee recommended that the developer assess whether the paper chart review is still needed, since it can increase the reporting burden.
- The Committee agreed the measure meets the Feasibility criterion.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-11; No Pass-1** *4b. Usability:* **H-5; M-6; L-1; I-0**

Rationale:

- The measure is used for reporting in CMS' Medicaid CHIP Child Core Set, a core set of health quality measures for children enrolled in Medicaid/Children's Health Insurance Program (CHIP); NCQA State of Health Care Annual Report, an annual report published by NCQA that summarizes findings on quality of care; NCQA Quality Compass, a tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance; and CMS Health Insurance Market Quality Rating System, a measure set that addresses areas of clinical quality management, enrollee experience, and plan efficiency, affordability and management.
- The developer reported a slight improvement for commercial plans over the past three years, increasing from 77.3% in 2014 to 78.41% in 2016. The developer reported a similar small improvement for Medicaid plans over the past three years, increasing from 58.71% in 2014 to 61.7% in 2016. The developer concluded these rates suggest an opportunity for continued performance improvement.
- The Committee stated that insurers should take a more active role in using the measure results to increase access to healthcare for children.
- The Committee agreed that the measure meets the Use criterion.
- The Committee agreed that the measure meets the Usability criterion.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-12**; **No-0**

Rationale

- The Committee recommended the measure for continued endorsement.

7. Public and Member Comment

NQF did not receive any comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Vote (June 10, 2019): Yes-14; No-0

CSAC Decision: Approved for continued endorsement

9. Appeals

No appeals were received.

1407 Immunizations for Adolescents

Submission | Specifications

Description: Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Numerator Statement: Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

Denominator Statement: Adolescents who turn 13 years of age during the measurement year.

Exclusions: This measure excludes patients who have a contraindication for the vaccine and patients who use hospice services during the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 2/7/2019

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

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

1a. Evidence: **H-1**; **M-11**; **L-0; I-0**; 1b. Performance Gap: **H-3**; **M-8**; **L-0**; **I-1**

Rationale:

- This maintenance measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.
- Since the Committee's last full review, Human Papilloma Virus (HPV) vaccination has been added to this measure.
- Committee members noted that the measure is based on evidence from the Advisory Committee on Immunization Practices (ACIP) guidelines, which are endorsed by the Centers for Disease Control and Prevention. The discussion centered on the disparity between the measure criteria of receiving the HPV vaccine before age 13, and the child vaccination guidelines as outlined by ACIP, which allow for later administration. Committee members requested that the developer provide disparities information during the next submission of the measure.
- The Committee agreed that this measure met the Evidence criterion.
- The developer presented data from previous years' performance for Medicare, Medicaid and commercial health plans.
- The measure demonstrates year-over-year performance improvement for each plan type and a consistent 6 to 12-point standard deviation from the mean demonstrating continued quality improvement opportunities.

- The Committee noted the significant variability in performance rates is largely driven by performance related to the HPV component, with less variability for the other two vaccinations included within the measure. It was noted that this did not detract from the importance of the measure, and the Committee determined that a performance gap and opportunity for improvement exist.
- The Committee agreed that this measure met the Performance Gap criterion.

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

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

2a. Reliability: **H-0; M-12; L-0; I-0** 2b. Validity: **H-0; M-12; L-0; I-0**

<u>Rationale</u>:

- The developer presented score-level reliability testing using the beta-binomial method outlined by Adams (2009; signal to noise). The developer did not conduct data element level reliability testing.
- The developer concluded generally high reliability across Medicaid and commercial health plans for the composite measure, as well as each of the vaccines in the composite. Specifically, the developer stated the measure is reliable at a statistic of > 0.7. It found the lowest 10th percentile plans achieve reliability between 0.85-0.94, indicating high reliability for both the composite as well as each of the measures in the composite.
- The developer did not conduct data element level reliability testing even though the measure permits multiple data sources. Reliability of the measure depends on correct abstraction of immunization data from health records, correctness of state immunization registry data, and health plan claims data. The developer does not address the stability of the metric given the multiple data sources.
- The Committee agreed that the measure meets the Reliability criterion.
- Construct validity was tested via correlation analysis of composite measure and individual rates compared with Childhood Immunization Status measure and Adolescent Well Care Visits measure rates. The developer concluded there were moderate to strong correlations.
- Commercial and Medicaid plans demonstrated comparable Pearson Correlation Coefficients between the composite score as well as vaccines in the composite, ranging between 0.4 and 0.8
- Commercial and Medicaid plans demonstrated comparable Pearson Correlation Coefficients between the composite score as well as with measure vaccines when compared to *Childhood Immunization Status* measure vaccines, ranging between 0.3 and 0.8
- Commercial and Medicaid plans demonstrated variable Pearson Correlation Coefficients for the composite score and measure vaccines compared to Adolescent Well Care Visits measure. Commercial plans ranged from 0.1 to 0.5 for measure vaccines and *Adolescent Well Care Visits* measure. Medicaid plans were consistent at 0.5 for measure vaccines and *Adolescent Well Care Visits* measure.
- Face validity was determined by a technical committee at NCQA (Committee on Performance Measurement), informed by measure testing, and a public comment. The multi-stakeholder advisory panel concluded unanimously the measures had good face validity to assess receipt of vaccines among adolescents. No quantitative data were provided on the face validity assessments.

- The Committee expressed concerns regarding coding and appropriate documentation of the data in its discussion of the overall validity of the measure.
- Ultimately, the Committee agreed that the measure meets the Validity criterion.

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3. Feasibility: H-5; M-6; L-1; I-0

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

Rationale:

- An issue raised by the Committee regarding the measure's feasibility is related to the review of paper charts, which are burdensome and expensive even with a statistically powered sample of 411 patients.
- The Committee agreed that the measure meets the Feasibility criterion.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-12; No Pass-0** *4b. Usability:* **H-5; M-7; L-0; I-0**

Rationale:

- The measure is reported as part of the 2016 Medicaid Child Core Set.
- The Committee agreed that the measure meets the Use criterion.
- NCQA reports year-over-year improvements for both Medicaid and Commercial plans.
- The Committee agreed that the measure meets the Usability criterion.

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5. Related and Competing Measures

- This measure is related to two measures, NQF #0038 and NQF #3483.
- NQF #0038 Childhood Immunization Status captures the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.
- NQF #3483 Adult Immunization Status assesses the percentage of adults 19 years of age and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
- No competing measures noted.

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6. Standing Committee Recommendation for Endorsement: **Yes-12**; **No-0**

Rationale

- The Committee recommended the measure for continued endorsement.

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7. Public and Member Comment

NQF did not receive any comments following the Committee's evaluation of the measure.

8. Consensus Standards Approval Committee (CSAC) Vote (June 10, 2019): Yes-12; No-2

CSAC Decision: Approved for continued endorsement

9. Appeals

No appeals were received.

1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Submission | Specifications

Description: The percentage of children 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year.

Numerator Statement: Children who received at least one well-child visit with a PCP during the measurement year.

Denominator Statement: Children 3-6 years of age during the measurement year.

Exclusions: This measure excludes children in hospice.

Adjustment/Stratification: No risk adjustment or risk stratification.

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 2/7/2019

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

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

1a. Evidence: **Accepted vote from Committee's prior evaluation**; 1b. Performance Gap: **H-9; M-3; L-0; I-0;**

Rationale:

- This maintenance measure assesses the percentage of children 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year.
- The Committee stated that while the evidence is not supported by randomized controlled trials, this does not necessarily undercut the measure, as it is still in accordance with the American Academy of Pediatrics' (AAP) Bright Futures recommendations.
- The Committee accepted the vote from its prior evaluation on evidence.
- The Committee noted there is a disparity in performance between commercial insurance plans and Medicaid plans.
- The developer summarized performance gap data at the health plan level: In 2016, there was about a 26-percentage point difference between commercial plans in the 10th and 90th percentiles and a 22-percentage point difference for Medicaid plans.
- The Committee agreed that the measure meets the Performance Gap criterion.

---

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-3; M-9; L-0; I-0** 2b. Validity: **H-2; M-10; L-0; I-0**

Rationale:

- The developer conducted empirical score-level reliability and validity testing.

- The developer addressed a former concern and added a new denominator exclusion for patients in hospice. Patients in hospice will not necessarily benefit from preventive care, so it is not appropriate to assess them for receipt of well-child visits.
- The developer provided measure score reliability using the beta-binomial model (signal to noise ratio) and 2016 HEDIS data (405 commercial plans and 243 Medicaid plans).
- The reliability score for commercial plans was 1.00 and the 10th to 90th percentile range was 0.96-1.00. For Medicaid plans, the statistics were 0.99 and 0.93-1.00, respectively.
- The developer concluded the measure has high reliability.
- The developer did not conduct data element level reliability testing even though multiple data sources may be used: The measure has an administrative data only option and an administrative data + medical record review option. Reliability of the measure is dependent on correct abstraction of well-child visit data from health records. The developer does not offer an analysis of these data sources relative to the stability of the metric.
- The Committee agreed that the measure meets the Reliability criterion.
- The developer assessed construct validity against other HEDIS measures and face validity.
- Pearson Correlation Coefficients were calculated for three aspects of weight assessment counseling (BMI percentile, counseling for nutrition, counseling for physical activity); Children Access Primary Care Provider 25 months-6 years; Childhood Immunization Status—All Vaccines; Well-Child Visits in the First 15 Months of Life. Correlation coefficients ranged from 0.4 to 0.8; all correlations significant at $p<0.0001$. The developer concluded the results indicate moderate to strong positive correlation of the hypothesized associations.
- Face validity was assessed by three panels: Child Health Measurement Advisory Panel; Technical Measurement Advisory Panel; Committee on Performance Measurement. The developer states the panels concluded "with good agreement" that the measure is specified to accurately assess well-child visits in health plans." No quantitative representation of agreement was provided.
- The Committee agreed that the measure meets the Validity criterion.

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

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

Rationale:

- The Committee noted that the measure can be collected by either electronic medical records (EMRs) or paper chart review; it also noted that as the country becomes increasingly less dependent on paper records, the feasibility of this measure will continue to improve.
- During the next maintenance review of the measure, the Committee recommended that the developer assess whether the paper chart review is still needed, since it can increase the reporting burden.
- The Committee agreed that the measure meets the Feasibility criterion.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-11; No Pass-1** *4b. Usability:* **H-3; M-8; L-1; I-0**

Rationale:

- The measure is used for reporting in CMS' Medicaid CHIP Child Core Set, a core set of health quality measures for children enrolled in Medicaid/Children's Health Insurance Program (CHIP); NCQA State of Health Care Annual Report, an annual report published by NCQA summarizes findings on quality of care; NCQA Quality Compass, a tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance; and CMS Health Insurance Market Quality Rating System, a measure set that consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability and management.
- The Committee agreed that the measure meets the Use criterion.
- The developer reported a slight improvement in performance for commercial plans over the past three years, increasing from 73.71% in 2014 to 75.45% in 2016. Performance was steady over the past three years for Medicaid plans (71.91% in 2014, 72.17% in 2016). The developer concluded these rates suggest opportunity for continued performance improvement.
- The Committee stated that while the measure is in wide use, there has not been a notable increase in health plan performance year over year. The Committee recommended that plans move beyond collecting the data to actively using the data to improve healthcare access for children.
- The Committee recommended that the developer focus on the content of the well-child visits in the future, rather than the mere existence of them. For instance, the Committee noted that the developer could include important social determinants of health (SDOH) as a part of the well-child visit specifications because SDOH, such as adverse childhood events, nutrition, domestic violence, and housing, are known to impact health. The Committee stated that this information is readily available in many cases, since numerous EMRs capture information on whether a provider asked about specific SDOHs.
- The Committee agreed that the measure meets the Usability criterion.

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5. Related and Competing Measures

- No related or competing measures noted.

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6. Standing Committee Recommendation for Endorsement: **Yes-12**; **No-0**

Rationale

- The Committee recommended the measure for continued endorsement.

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7. Public and Member Comment

NQF did not receive any comments following the Committee's evaluation of the measure.

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8. Consensus Standards Approval Committee (CSAC) Vote (June 10, 2019): Yes-14; No-0

CSAC Decision: Approved for continued endorsement

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9. Appeals

No appeals were received.

Appendix B: Prevention and Population Health Committee Portfolio—Use in Federal Programs[a]

*Measures added to the Prevention and Population Health Standing Committee Portfolio since the last measure evaluation cycle.

**Change in NQF measure number, based on eMeasure renumbering system.

NQF #	Title	Federal Programs: Finalized or Implemented as of May 31, 2019
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0032	Cervical Cancer Screening (CCS)	Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS); Medicaid
0034	Colorectal Cancer Screening (COL)	Medicare Shared Savings Program; Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0038	Childhood Immunization Status (CIS)	Merit-Based Incentive Payment System (MIPS) Program; Qualified Health Plan (QHP) Quality Rating System (QRS)
0039	Flu Vaccinations for Adults Ages 18 and Older	Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
0041	Preventive Care and Screening: Influenza Immunization	Medicare Shared Savings Program; Merit-Based Incentive Payment System (MIPS) Program
0041e	Preventive Care and Screening: Influenza Immunization	
0226	Influenza Immunization in the ESRD Population (Facility Level)	No federal program usage specified for this measure.
0272	Diabetes Short-Term Complications Admission Rate (PQI 01)	Medicaid
0273	Perforated Appendix Admission Rate (PQI 2)	No federal program usage specified for this measure.
0274	Diabetes Long-Term Complications Admission Rate (PQI 03)	No federal program usage specified for this measure.
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	Medicaid
0277	Congestive Heart Failure Rate (PQI 08)	Medicaid

[a] Per CMS Measures Inventory Tool as of 8/1/2019

NQF #	Title	Federal Programs: Finalized or Implemented as of May 31, 2019
0279	Community-Acquired Pneumonia Admission Rate (PQI 11) (Previously named "Bacterial Pneumonia Admission Rate")	No federal program usage specified for this measure.
0280	Dehydration Admission Rate (PQI 10)	No federal program usage specified for this measure.
0281	Urinary Tract Infection Admission Rate (PQI 12)	No federal program usage specified for this measure.
0283	Asthma in Younger Adults Admission Rate (PQI 15)	Medicaid
0285	Lower-Extremity Amputation among Patients with Diabetes Rate (PQI 16)	No federal program usage specified for this measure.
0421** (formerly 2828)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Merit-Based Incentive Payment System (MIPS) Program
0421e** (formerly 3039)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Million Hearts; Merit-Based Incentive Payment System (MIPS) Program; Medicaid Promoting Interoperability Program
0431	Influenza Vaccination Coverage Among Healthcare Personnel	Hospital Compare; Hospital Outpatient Quality Reporting; Prospective Payment System-Exempt Cancer Hospital Quality Reporting; Ambulatory Surgical Center Quality Reporting; Hospital Inpatient Quality Reporting; Inpatient Psychiatric Facility Quality Reporting; Inpatient Rehabilitation Facility Quality Reporting; Long-Term Care Hospital Quality Reporting; Home Health Value Based Purchasing
0509	Diagnostic Imaging: Reminder System for Screening Mammograms	Merit-Based Incentive Payment System (MIPS) Program
0638	Uncontrolled Diabetes Admission Rate (PQI 14)	No federal program usage specified for this measure.
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Ambulatory Surgical Center Quality Reporting; Hospital Compare; Hospital Outpatient Quality Reporting; Merit-Based Incentive Payment System (MIPS) Program
0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	Nursing Home Quality Initiative; Long-Term Care Hospital Quality Reporting
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	Nursing Home Quality Initiative

NQF #	Title	Federal Programs: Finalized or Implemented as of May 31, 2019
1392	**Well-Child Visits in the First 15 Months of Life***	Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
1407	Immunizations for Adolescents	Merit-Based Incentive Payment System (MIPS) Program; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
1516	**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life***	Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
1659	Influenza Immunization	Hospital Inpatient Quality Reporting; Inpatient Psychiatric Facility Quality Reporting
2372	Breast Cancer Screening	Medicare Part C Star Rating; Merit-Based Incentive Payment System (MIPS) Program; Medicare Shared Savings Program; Medicaid; Qualified Health Plan (QHP) Quality Rating System (QRS)
2511	Utilization of Services, Dental Services	No federal program usage specified for this measure.
2517	Oral Evaluation, Dental Services	No federal program usage specified for this measure.
2528	Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services	No federal program usage specified for this measure.
2689	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	No federal program usage specified for this measure.
2695	Follow-Up after Emergency Department Visits for Dental Caries in Children	No federal program usage specified for this measure.

Appendix C: Prevention and Population Health Standing Committee and NQF Staff

STANDING COMMITTEE

Thomas McInerny, MD (Co-chair)
Retired
Honeoye Falls, New York

Amir Qaseem, MD, PhD, MHA (Co-chair)
American College of Physicians
Philadelphia, Pennsylvania

John Auerbach, MBA
Trust for America's Health
Washington, District of Columbia

Michael Baer, MD
Cotiviti
Atlanta, Georgia

Ron Bialek, MPP, CQIA
Public Health Foundation
Washington, District of Columbia

J. Emilio Carrillo, MD, MPH
Weill Cornell Medicine, Weill Cornell Graduate School of Medical Sciences, Massachusetts General Hospital
New York, New York

Barry-Lewis Harris, II, MD
Corizon Health
Memphis, Tennessee

Catherine Hill, DNP, APRN
Texas Health Resources
Frisco, Texas

Ronald Inge, DDS
Delta Dental of Missouri
St. Louis, Missouri

Patricia McKane, DVM, MPH
Michigan Department of Community Health
St. Lansing, Michigan

Amy Minnich, RN, MHSA
Geisinger Health System
Danville, Pennsylvania

Marcel Salive, MD, MPH
National Institute on Aging
Rockville, Maryland

Jason Spangler, MD, MPH
Amgen, Inc.
Washington, District of Columbia

Matt Stiefel, MPA, MS
Kaiser Permanente
Oakland, California

Michael Stoto, PhD
Georgetown University
Washington, District of Columbia

Steven Teutsch, MD, MPH
University of California, Los Angeles and University of Southern California
Los Angeles, California

Arjun Venkatesh, MD, MBA
Yale University School of Medicine
New Haven, Connecticut

NQF STAFF

Elisa Munthali, MPH
Senior Vice President, Quality Measurement

Debjani Mukherjee, MPH
Senior Director

Samuel Stolpe, PharmD, MPH
Senior Director

Kate Buchanan, MPH
Senior Project Manager

Yetunde Ogungbemi, BS
Project Manager

Robyn Y. Nishimi, PhD
Senior NQF Consultant

Appendix D: Measure Specifications

1392 Well-Child Visits in the First 15 Months of Life

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Children who received six or more well-child visits with a PCP during their first 15 months of life.

NUMERATOR DETAILS

Health plans can choose to report this measure using 1) administrative claims only or 2) administrative claims supplemented with medical record review (hybrid method). Both methods are described below.

ADMINISTRATIVE:

Patients who received six or more well-child visits (Well-Care Value Set), on different dates of service, during their first 15 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

MEDICAL RECORD:

Patients with six or more visits with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.

- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

DENOMINATOR STATEMENT

Children who turn 15 months old during the measurement year.

DENOMINATOR DETAILS

Children who turn 15 months as of December 31 of the measurement year.

EXCLUSIONS

This measure excludes children in hospice.

EXCLUSION DETAILS

This measure excludes children who use hospice services (Hospice Value Set) any time during the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Refer to items S.9 for additional denominator details and attached value sets for codes.

Step 1. Determine the eligible population. To do so, identify children who turn 15 months of age during the measurement year.

Step 2. Search for an exclusion in the patient's history. Exclude these patients from the eligible population.

Step 3. Determine the numerator. To do so, identify patients with at least six well-child visits during their first 15 months of life.

Step 3. Calculate the rate. Refer to items S.9 for additional denominator details and attached value sets for codes.

Step 1. Determine the eligible population. To do so, identify children who turn 15 months of age during the measurement year.

Step 2. Search for an exclusion in the patient's history. Exclude these patients from the eligible population.

Step 3. Determine the numerator. To do so, identify patients with at least six well-child visits during their first 15 months of life.

Step 3. Calculate the rate.

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1407 Immunizations for Adolescents

STEWARD

National Committee for Quality Assurance

DESCRIPTION

Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

NUMERATOR DETAILS

See attached value sets.

ADMINISTRATIVE:

For meningococcal, Tdap and HPV, count only evidence of the antigen or combination vaccine.

Meningococcal: At least one meningococcal vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the member's 11th and 13th birthdays.

Tdap: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set) with a date of service on or between the member's 10th and 13th birthdays

HPV: At least two HPV vaccines (HPV Vaccine Administered Value Set), with different dates of service on or between the member's 9th and 13th birthdays. There must be at least 146 days between the first and second dose of the HPV vaccine.

OR

At least three HPV vaccines (HPV Vaccine Administered Value Set), with different dates of service on or between the member's 9th and 13th birthdays.

All Vaccines (Meningococcal, Tdap, HPV): Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

MEDICAL RECORD:

For meningococcal, Tdap and HPV, count only evidence of the antigen or combination vaccine.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

--A note indicating the name of the specific antigen and the date of the immunization.

--A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal vaccination, do not count serogroup B (MenB) vaccines. Immunizations documented under a generic header of "meningococcal" and generic documentation that the "meningococcal vaccine" was administered meet criteria.

Immunizations documented using a generic header of "Tdap/Td" can be counted as evidence of Tdap. The burden on organizations to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

DENOMINATOR STATEMENT

Adolescents who turn 13 years of age during the measurement year.

DENOMINATOR DETAILS

Adolescents who turn 13 years of age during the measurement year.

EXCLUSIONS

This measure excludes patients who have a contraindication for the vaccine and patients who use hospice services during the measurement year.

EXCLUSION DETAILS

See attached value sets.

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

Either of the following meet exclusion criteria:

--Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.

--Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the eligible population: identify adolescents 13 years of age by the end of the measurement year.

Step 2. Exclude patients who had an anaphylactic reaction to the vaccines or its components.

Step 3: Determine the numerator: identify the number of patients who have received the meningococcal vaccine, Tdap vaccine, and HPV vaccine series.

Step 4. Calculate a rate for each individual vaccination as well as combinations of vaccinations (All vaccine rate: Tdap, meningococcal, and HPV) Step 1. Determine the eligible population: identify adolescents 13 years of age by the end of the measurement year.

Step 2. Exclude patients who had an anaphylactic reaction to the vaccines or its components.

Step 3: Determine the numerator: identify the number of patients who have received the meningococcal vaccine, Tdap vaccine, and HPV vaccine series.

Step 4. Calculate a rate for each individual vaccination as well as combinations of vaccinations (All vaccine rate: Tdap, meningococcal, and HPV)

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1516 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of children 3-6 years of age who had one or more well-child visits with a primary care physician during the measurement year.

TYPE

Process

DATA SOURCE

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Children who received at least one well-child visit with a PCP during the measurement year.

NUMERATOR DETAILS

Health plans can choose to report this measure using 1) administrative claims only or 2) administrative claims supplemented with medical record review (hybrid method). Both methods are described below.

ADMINISTRATIVE:

Patients with at least one well-child visit (Well-Care Value Set) with a PCP during the measurement year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

MEDICAL RECORD:

Patients with at least one well-child visit with a PCP during the measurement years. The PCP does not have to be the practitioner assigned to the child.

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.

- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

DENOMINATOR STATEMENT

Children 3-6 years of age during the measurement year.

DENOMINATOR DETAILS

Children 3-6 years of age as of December 31 of the measurement year.

EXCLUSIONS

This measure excludes children in hospice.

EXCLUSION DETAILS

This measure excludes children who use hospice services (Hospice Value Set) any time during the measurement year.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Refer to items S.9 for additional denominator details and attached value sets for codes.

Step 1. Determine the eligible population. To do so, identify children who are 3-6 years of age by December 31 of the measurement year.

Step 2. Search for an exclusion in the patient's history. Exclude these patients from the eligible population.

Step 3. Determine the numerator. To do so, identify patients with at least one well-child visit during the measurement year.

Step 3. Calculate the rate. Refer to items S.9 for additional denominator details and attached value sets for codes.

Step 1. Determine the eligible population. To do so, identify children who are 3-6 years of age by December 31 of the measurement year.

Step 2. Search for an exclusion in the patient's history. Exclude these patients from the eligible population.

Step 3. Determine the numerator. To do so, identify patients with at least one well-child visit during the measurement year.

Step 3. Calculate the rate.

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National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

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