

Meeting Summary

Core Quality Measures Collaborative

Pediatrics Workgroup: Orientation Web Meeting

The National Quality Forum (NQF) convened a closed session web meeting for the Pediatrics Workgroup on December 18, 2018.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff reviewed the following meeting objectives:

- Provide an overview of the CQMC and workgroup charge,
- Discuss the CQMC measure selection principles,
- Review past work and current measure set, and
- Identify potential sources for additional measures.

Overview of the CQMC and Workgroup Charge

NQF staff reviewed the background and aims of the CQMC, current measure sets, project approach, and timeline. NQF, in collaboration with CMS and AHIP, will convene the workgroups over a series of web meetings to provide input on measure selection criteria, evaluate current measure sets to provide recommendations for removal and identify potential gaps, identify potential sources for additional measures, evaluate measures for addition to the core sets, prioritize measure gaps, and provide guidance on dissemination and adoption of the core sets.

Measure Selection Principles Discussion

Current Principles for Measure Selection:

- Measure sets must be aimed at achieving the three-part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care.
- NQF-endorsed measures are preferred. In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process, and may have been published in a specialty-appropriate, peer-reviewed journal and have a focus that is evidence-based.
- Data collection and reporting burden must be minimized.
- Measure sets for clinicians should be as parsimonious as possible and should focus on those measures delivering the most value.
- Measures should be meaningful to and usable by consumers, physicians, other clinicians, purchasers and payers, and also applicable to different patient populations.

- Measures that are currently in use by physicians, including those reported through qualified clinical data registries, measure patient outcomes, and have the best potential to drive improvement are preferred. Measure sets will be continually iterated upon to add new measures and retire existing measures.
- Measure sets should provide a comprehensive picture of quality, inform patient-centered care, be chosen from the existing measurement landscape to address outcomes of care, overuse, and underuse.
- Overuse and underuse measures should both be included as well as total cost of care measures, where appropriate, that are tested and feasible for implementation.
- Priority should be given to measures that reflect cross-cutting domains of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation).
- Patient outcomes measures should be evidence-based and should focus on those areas where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.
- As with all measures, those which assess performance in payment and delivery reform models should be evidence-based, apply at the appropriate level of analysis, and strive to measure progress toward attaining the Triple Aim of improving clinical quality, patient experience, and affordable cost.

NQF staff provided an update on the refinement of the core measure set selection principles and shared a comparison of the CQMC principles with those used by other state and federal initiatives. NQF staff stated that a memo will be sent out in December 2018 to obtain the full Collaborative's feedback on the updated principles before finalizing them.

A health improvement collaborative member noted the importance of highlighting the ability to improve on the measure and overall measure performance in the selection principles. Additionally, the member shared that the ability to adjust for socioeconomic factors or other factors outside of the provider's control should be considered when selecting measures.

A health plan member agreed with the importance of using appropriate risk adjustment methodology when possible, but noted the difficulty in figuring out how to risk adjust for social determinants of health. The member stated that the pediatric population is unique as most children are healthy most of the time, but there are also children who are very sick. The member suggested a need to adjust for this characteristic of the patient population.

A health plan member shared that the selection principles should address burden, alignment, and accountability. A health plan member suggested dividing the selection principles to reflect those related to individual measures and those applicable to the set as a whole. A provider group member suggested the pediatric measure set should include outcome measures and emphasized the importance of patient-reported outcomes measures. The member noted that while parents or caregivers may be the individuals filling out the surveys, patient-reported outcomes are equally important in the pediatric population as in the adult population.

Review of Current Core Set

Current measures in the Pediatric Core Set:

- NQF# 0038: Childhood Immunization Status (CIS)
- N/A: Immunizations for Adolescents (IMA)
- NQF# 1448: Developmental Screening in the First Three Years of Life
- NQF# 0033: Chlamydia Screening for Women

- NQF# 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- NQF# 1516: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- NQF# 1799: Medication Management for People with Asthma (MMA)
- NQF# 0002: Appropriate Testing for Children with Pharyngitis (CWP)
- NQF# 0069: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

A health improvement collaborative member asked for additional information about the previous Workgroup's decision to separate applicability to ACOs versus PCMHs and stated that many of the measures can also apply at the clinician level. NQF staff shared that, when possible, they will summarize content previously discussed to inform Workgroup members and will revisit this topic before the Workgroup begins discussing measures in the core set. A co-chair asked about the intended audience or group (e.g., all pediatric patients versus pediatric patients in an ACO) being measured. A payer representative responded that the aim is to create a holistic measure set for all payers, both public and private, to align around for a specific clinical area, in this case for the entire pediatric population.

A co-chair asked about current use of the pediatric core set. A payer representative responded that from the public payer perspective, most pediatric measurement is through Medicaid. The payer representative noted differences in adult and pediatric measurement and shared that most pediatricians are not involved in Merit-based Incentive Payment System (MIPS). A health plan member shared that they use the core set measures for their Medicaid and commercial pediatric populations.

A health plan member noted challenges with the developmental screening measure (#1448) as it is not a classic HEDIS measure and required significant work to build. The health plan member shared that there is a state-level requirement to reach the 90th percentile on the asthma measure (#1799) to receive full reimbursement. The health plan member stated that due to issues regarding the asthma diagnosis (e.g., individuals may receive an inhaler during an urgent care or emergency room visit without an asthma diagnosis) it is difficult to reach the cutoff. A co-chair noted the developmental screening measure (#1448) does not completely align with the Bright Futures measure in terms of measurement period. The recommendation in Bright Futures is "at 9, 18, and 30 months" while measure #1448 specifies "by 12, 24, and 36 months".

A health plan member shared difficulties with the immunization measures (#0048 and N/A Immunizations for Adolescents) due to some states' inability to capture immunization status with only claims data. Claims data can capture that an immunization was provided, but often the type of immunization is only captured by the state. A health improvement collaborative member suggested that the weight assessment and counseling measure (#0024) may be topped out and noted that the appropriate testing for pharyngitis measure (#0002) is no longer endorsed and should be discussed for possible removal. All measures currently in the core set will be discussed in subsequent meetings to determine if they should continue to be included.

A health plan member noted challenges with the look-back period for the chlamydia measure (#0033). Another health plan member shared that they can easily capture data because it comes through as claims, but noted difficulty when individuals access care through certain clinics. A medical society member noted that the previous Workgroup decided that measurement should occur at the ACO level rather than the individual clinician level since various individuals or organizations can be accountable based on age range and tracking can be difficult. A co-chair asked the Workgroup to consider defining the age range of the pediatric population specific to the core set. The Workgroup

will discuss the topics of measurement level and age range further during the next meeting.

Identification of Future Measures

NQF staff advised that NQF would scan its portfolio and major public programs for potential measures and encouraged the Workgroup to share gap areas and measures to consider for core set inclusion.

A co-chair noted that mental health is a gap in the core set. A health improvement collaborative member agreed that behavioral health it is a top priority and stated they will share their work on behavioral health measures. Other gaps discussed by the Workgroup were substance use screening, depression screening, patient experience measures (including patient and family engagement), social determinants of health, and care coordination. A co-chair noted that the well-child visits measure (#1516) is the “access” measure used in the set. The Workgroup was interested in mapping the pediatric core set to other child core sets, and NQF staff confirmed they will provide this information for the next meeting.

SharePoint Tutorial/Next Steps

NQF staff briefly introduced the [CQMC SharePoint site](#) and shared that all CQMC-related correspondence should be sent to CQMC@qualityforum.org. NQF’s next steps include finalizing the selection principles by December/January 2018 and performing an environmental scan of measures to discuss during the next workgroup meetings in February/March 2019.