DATE: December 8, 2016

TO: Performance Measures Coordinating Committee (PMCC)

FROM: Pediatrics Measures Selection Work Group
Susie Dade, Deputy Director, Washington Health Alliance

RE: FINAL Pediatric Measures Recommendations

INTRODUCTION AND BACKGROUND INFORMATION

In October, the PMCC received the preliminary recommendations from the Pediatric Measures Work Group. The PMCC took action to release the recommendations for public comment during the month of November. There was a public comment period for two and a half weeks during November and the results of that public comment period are detailed in a separate attachment. The Pediatric Measures Work Group met on December 5 to review the feedback and finalize its recommendations to the PMCC. These final recommendations are presented below.

As a reminder, the Work Group was formed for the specific purpose of reviewing and exploring potential pediatric health measures. Their charge was as follows:

> *Consider all of the pediatric-related measures in the current Common Measure Set and make recommendations regarding which measures to keep, remove and/or replace, or add, noting that the total number of pediatric-related measures should not exceed 17 measures.*

Membership on the Pediatrics Measures Work Group is listed on page 6.

The work group was instructed to formulate their recommendations using the same measure selection criteria used in 2014 and 2015, and considering what is feasible to implement in Washington State *with currently available data sources* and resources. The Washington Health Alliance provided staff support for this ad hoc work group, providing both facilitation and technical expertise.

RECOMMENDATIONS

Detail on each of the measures listed below is included in a separate attachment.

<u>Recommendation A</u>: Keep the following 12 measures in the Common Measure Set. The measures have been previously approved and are in current use. Utilize the most up-to-date measure specifications available for each measure.

Pediatric-only

1. Childhood Immunization Status by Age 2 (Combo 10)
2. Immunizations for Adolescents by Age 13
3. Oral Health: Primary Caries Prevention as Part of Primary Care Visit *(Medicaid population only)*
4. Child and Adolescent Access to Primary Care Practitioners
5. Appropriate Testing for Children with Pharyngitis
6. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
7. Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Pediatric and Adult

8. Immunization for Influenza
9. Chlamydia Screening for Women
10. Mental Health Service Penetration
11. Substance Use Disorder Service Penetration
12. Follow-up After Hospitalization for Mental Illness @ 7 days and 30 days

<u>Recommendation B</u>: Keep the following measure in the Common Measure Set, but modify it as noted below:

13. Medication Management for People with Asthma: Percentage of members 5-85 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least ~~50%~~ **75%** of the treatment period.

<u>Recommendation C</u>: Add the following three measures to the Common Measure Set, effective 2017.

14. Well Child Visits in the First Fifteen Months of Life
15. Follow-up Care for Children Prescribed ADHD Medication
16. Audiological Evaluation No Later than Three Months

<u>Recommendation D</u>: Remove the following measure from the Common Measure Set. This measure has been retired by NCQA. HPV (for adolescent females and males) is now included in the "Immunizations for Adolescents by Age 13" measure.

- Human Papillomavirus Vaccine for Female Adolescents by Age 13

After further consideration, the Pediatric Measures Work Group is <u>withdrawing</u> its recommendation to add the following two measures to the Common Measure Set. A brief rational is included below for each measure.

1. **Lead Screening in Children (LSC) (Measure Steward: NCQA HEDIS, not NQF-Endorsed)**
   This NCQA HEDIS measure is specified for the Medicaid population only. The Health Care Authority has stated that they are required to continue measuring lead screening using a *different mechanism* to meet federal reporting requirements in addition to requiring MCOs to report on the NCQA LSC measure. There seems to be enough confusion around this area of measurement that the Work Group felt it appropriate to pull the recommendation to include the HEDIS measure in the Common Measure Set. Instead, the Work Group recommends that the state undertake a review of the DOH, HCA and HEDIS measure definitions to see if there is an opportunity to gain greater alignment for future measurement and reporting.

2. **PCP Visit After ER Visits for Asthma (Measure Steward: PQMP, not NQF-Endorsed)**
   A majority of respondents during the public comment period were either unsupportive or not sure about this measure. A number of concerns underlie the Work Group's reassessment of this measure: (1) difficulty in accurately diagnosing asthma, particularly in the ER setting; (2) concern that claims will not reliably pick up telephonic visits which may be an important mechanism for follow-up care for low acuity asthma ER visits; (3) provider type (required to specify primary care clinicians) is not always a reliable field in Medicaid claims; and, (4) small numbers will necessitate results only at the county level (not medical group or clinic) which will be less actionable for this particular measure.

Upon further consideration, the Pediatric Measures Work Group was unable to come to a firm conclusion about whether to recommend that the following measure should be included in the Common Measure Set.

- **Pediatric All-Cause Hospital Readmissions (Measure Steward: Center of Excellence for Pediatric Quality Measurement, NQF-Endorsed #2392)**

A vote among 12 of 13 members present at the December 5 Work Group meeting resulted in a split: 5 members favored recommending that the measure be included in the Common Measure Set and 7 members favored withdrawing the recommendation but adding it to the "parking lot" for future consideration.

A brief summary of key issues discussed by the Work Group is presented below.

PROs – Include Measure in Common Measure Set

- Currently, there is only one pediatric measure that pertains to inpatient care, so adding this measure would strengthen the Common Measure Set.
- Readmissions are an important overall measure of health care outcomes related to inpatient care. Increasingly, hospitals are being held accountable for readmissions and having a measure that focuses in this area for the pediatric population is important.

CONS – Do Not Include Measure in Common Measure Set

- This will be an expensive, complicated and time-consuming measure to program*. It is not clear that there is a good ROI given that the results are likely to produce relatively small numbers for a limited number of hospitals in the state. Certain thresholds will have to be met before hospital-specific results will be publicly reported.
- Subject matter experts report that a limited number of clinical reasons dominate as reasons for pediatric readmissions. In community acute care hospitals, the primary reason for pediatric readmissions is typically Hyperbilirubinemia. In specialty pediatric hospitals, the primary reasons for readmissions are typically asthma, bronchiolitis, and seizures. It is unclear how much can be done in these specific areas to lower readmission rates when the clinical situation is serious.

Note: Should the PMCC elect to move forward with this measure, additional financial resources will be required to program, test and validate results for this measure as it is a new measure never used before in Washington.

"PARKING LOT" – MEASURES/TOPICS OF INTEREST FOR FUTURE CONSIDERATION

During the Work Group's process, they encountered several measures/topics they were very supportive of but that we had to set aside, primarily because (a) there was not a nationally vetted measure and/or (b) we could not identify a readily available and reliable data source in Washington state to support public reporting statewide. The Work Group asks that the following topics remain on a "parking lot" of pediatric measurement areas that should be considered a priority in the future as new measures and/or data sources emerge within the state, for example, a robust statewide clinical data repository that will support measurement and public reporting.

1. Depression screening by age 13 years of age
2. Maternal depression screening
3. Dyslipidemia screening for patients aged 12 years
4. Developmental Screening in the First Three Years of Life
5. Opioid prescribing for children and adolescents (measure should be consistent with CDC guidelines)
6. Lead Screening in Children
7. *Possible Addition of Pediatric All-Cause Readmissions*

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