



January 14, 2011

Agency for Healthcare Research and Quality
Office of Extramural Research, Education, and Priority Populations
Public Comment, CHIPRA PQMP Priorities
540 Gaither Rd.
Rockville, MD 20850

The Association of Maternal & Child Health Programs (AMCHP), the Council of State and Territorial Epidemiologists (CSTE) and the National Association for Public Health Statistics and Information Systems (NAPHSIS) want to applaud the efforts of the Agency for healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) for their work to develop a comprehensive set of quality measures under the Children's Health Insurance Program Reauthorization Act (CHIPRA) and to set broad priorities for the work of the Pediatric Quality Measures Program (PQMP). In particular, we applaud the work and underscore the importance of developing methods to increase state programs' and CMS's ability to rely on non-Medicaid and Children's Health Insurance Program (CHIP) data sources through improvement in public health sector measurement (e.g., birth certificate data, immunization surveys) as outlined in priority 1g of the Federal Register Notice. Public health measures and data are an important complement to other data sources and would help assure greater validity and reliability, and a more comprehensive picture of the impact of public insurance programs and related programs and supports on improving child outcomes.

Thank you for the opportunity to provide public comment on this important new child health initiative. The proposed children's health care quality measures are a first step in addressing an important need in this nation. In this age of cutting health care costs, we need to assure that we can monitor the quality of the health care provided. Quality measures are necessary to hold health care systems accountable for the quality of care provided to our children. Although the first measure set is not perfect, many good measures have been selected covering a broad set of issues. This provides a ready foundation upon which to build.

Our three organizations have joined efforts in commenting as we represent the three state public health organization affiliates most closely involved with childhood quality measures. Our joint response is attached. Please feel free to contact Dr. Bill Sappenfield [850-245-4497 or bill_sappenfield@doh.state.fl.us] or any of our organizations if you have any questions or need further information.

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**Public Comments on Children's Health Care Quality Measures by
Association of Maternal and Child Health Programs (AMCHP),
Council of State and Territorial Epidemiologists (CSTE), and
National Association of Public Health Statistics and Information Systems (NAPHSIS)**

January 14, 2011

I. Overall comments about the initiative

- AMCHP, CSTE and NAPHSIS applaud the efforts of AHRQ and CMS for their work to develop a comprehensive set of quality measures under CHIPRA and to set broad priorities for the work of the Pediatric Quality Measures Program (PQMP). In particular, we applaud the work and underscore the importance of developing methods to increase state programs' and CMS's ability to rely on non-Medicaid and CHIP data sources through improvement in public health sector measurement (e.g., birth certificate data, immunization surveys) as outlined in priority 1g of the Federal Register Notice. Public health measures and data are an important complement to other data sources and would help assure greater validity and reliability, and a more comprehensive picture of the impact of public insurance programs and related programs and supports on improving child outcomes.
- Thanks for the opportunity to provide comment on this important new child health initiative. The proposed children's health care quality measures are a first step in addressing an important need in this nation. In this age of cutting health care costs, we need to assure that we can monitor the quality of the care provided. Quality measures are necessary to hold health care systems accountable for the quality of care provided to our nation's children. Although the first measure set is not perfect with some not being strong quality measures, many good measures have been selected covering a broad set of issues. This provides a ready foundation upon which to build.
- The inclusion of childhood quality measures that draw from population based and public health data, where possible, provide the opportunity to provide measures, not only at the health plan level, but at other potentially useful levels (state, county, health district, school district) to improve the quality of child health care broadly. This approach also provides potential comparison groups to better understand the populations that health plans are serving and the impact of policy and program changes at the various levels on improving quality measures.
- CHIPRA quality measures focus on improving the quality of clinical care. These same measures are frequently influenced by the work of public health agencies and are used as public health measures. The overlap encourages coordination where appropriate. Proposed CHIPRA measures should be coordinated with ongoing U.S. Department of Health and Human Services prevention efforts such as the new Healthy People 2020.
- In order to properly evaluate quality of care provided to children, disparities by race, ethnicity and socioeconomic status must be examined to ensure that there are no differential patterns of diagnosis and treatment. Published articles and national reports (i.e. IOM Report: *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*) have identified racial and ethnic disparities in the provision of health care. Some disparities have been found with children's health care. CHIPRA should require the reporting of key quality measures for racial/ethnic groups and other

vulnerable population groups so that health plans can be held accountable for reducing these disparities where appropriate. This would require definitions and methods for collecting accurate race and ethnic information.

- Although the current effort focuses on quality health care measures, additional social and health indicators describing the children included in health plans would be informative and valuable. Risk adjustment cannot fully account for population differences when comparing these quality measures. These additional indicators could help explain some of the differences between Health plans.
- We appreciate the limited time period given to the agencies to implement such a large scale initiative. The time period and length chosen for this public comment limited our organizational ability to respond as thoroughly and detailed as desired. Hopefully further opportunities will be offered for providing further comment and more detailed comprehensive suggestions. We would strongly recommend including a public health epidemiologist with extensive knowledge in maternal and child health to serve on your next measure advisory committee. This person could contribute to the discussion of potential measures as well as the potential mechanisms to collect the information.

II. Overall comments about the selected measures

- For these measures, a child's age is very important. Currently, some recommended measure descriptions include all children or all children starting at a specific age. The upper age limit is not clearly stated for these measures nor in overall measures' description. This may reflect age eligibility differences between programs, but full age descriptions are needed for these measures.
- We recommend that AHRQ and CMS place as a priority an area for development and enhancement of methods for a standardized way of identifying children and youth with special health care needs (CYSHCN) at entry into health care service delivery systems (e.g., managed care) in order to report on health outcomes using key health indicators for this population of children who have unique health care needs. The CYSHCN Screener is a widely recognized tool for identifying children with special health care needs. It is unique because it asks parents whether or not they consider their child to have needs that are different from other children of a similar age. Such methods are used by the National Survey of Children with Special Health Care Need conducted by CDC and HRSA. Reporting measures for these special but important children will be more difficult as it focuses on a subpopulation of children.

III. Specific comments about the selected measures

Measure Number	LEGISLATIVE MEASURE TOPIC/Subtopic/ Current Measure label	Current Numerator	Current Denominator and Enrollment Criteria	Current Data Source	Evidence Grade	Est. Number of Medicaid and CHIP Enrollees At Risk of Poor Healthcare Quality
1	Frequency of ongoing prenatal care	Women in the denominator sample who had an unduplicated count of less than 21%, 21-40%, 41-60%, 61-80%, or more than 81% of expected visits, adjusted for the month of pregnancy at enrollment and gestational age	<p>Medicaid-enrolled women who delivered a live birth on/between Nov 6 of the yr prior to measurement yr & Nov 5 of the measurement yr</p> <p>Continuous enrollment 43 days prior to delivery through 56 days after delivery</p> <p>Data can be reported separately for adolescent women</p>	H	B&D	2.1 million births/year; 123,000 adolescents <17 gave birth ¹
<p>Comments:</p> <ul style="list-style-type: none"> An important subgroup for this measure is medically high risk women, especially women with previous poor pregnancy outcome. Their future children and Health Plans would benefit if these women receive prenatal care early and adequate prenatal services. In fact, these women frequently receive care coordination services to assure access. 						
2	Timeliness of prenatal care—the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization	Number of women in the denominator sample who had a prenatal visit in the first trimester or within 42 days of enrollment	<p>All deliveries during the measurement year</p> <p>Continuous enrollment 43 days prior to delivery through 56 days after delivery</p> <p>Data can be reported separately for adolescent women</p>	H	B&D	2.1 million births/year; 123,000 adolescents <17 gave birth ¹
<p>Comments:</p> <ul style="list-style-type: none"> An important subgroup for this measure is medically high risk women, especially women with previous poor pregnancy outcome. Their future children and Health Plans would benefit if these women receive prenatal care early and adequate prenatal services. In fact, these women frequently receive care coordination services to assure access. 						

3	Percent of live births weighing less than 2,500 grams	Number of resident live births less than 2500 grams	Number of resident live births in the State reporting period Data can be reported separately for adolescents	O ⁱ	B	2.1 million births/year at risk for LBW ¹
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Comments:

- Birth certificates are currently the most reliable source of infant birth weight on a population basis and potentially for health plans. The timeliness of this data source varies by state. Use of this data requires that state health departments have the infrastructure to accurately collect this information on a timely basis. Adequate resources are needed to assure this capability. In addition, states will need to develop an accurate and consistent mechanism for linking birth certificate data to health plan eligibility and encounter data. Some states already have this capability, but many do not. This will require additional resources. Birth certificates and birth certificates linked to other data sources provide a strong potential data source for other maternal and infant health care quality measures. Resources and efforts are needed to strengthen the data quality. Ohio's use of the data for health care quality purposes is a great example. (Donovan EF. Am J Obstet Gynecol. 2010 Mar;202(3):243.e1-8.) The Massachusetts Pregnancy to Early Life Longitudinal Study (PELL) is another example of a robust linked data system that has been used to assess quality of care.
- Although this is an important public health indicator for maternal and child health and impacts the future health of children, it is not clear this choice is a useful quality measure and one that can be readily influenced by health care plans. Other perinatal quality of care measures should be considered.

4	Cesarean rate for nulliparous singleton vertex	The number of women in the denominator who had a cesarean section	First live singleton births ≥ 37 weeks gestation with vertex presentation (no breech/transverse fetal positions)	O ⁱⁱⁱ or A ^{iv}	B	2.1 million total births/year at risk for C-section ¹
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Comments:

- Hospital discharge data linked with birth certificates can be a fairly accurate source for this quality measure. The availability, quality and timeliness of this linked data vary by state. Birth certificates are currently the best source for the obstetrical estimate of gestational age on a population basis. Hospital discharge data is a reliable information source for cesarean rates. Both data collection systems at a state level need sufficient resources to assure adequate infrastructure for timely accurate data collection and including linkage of this data to health care plan data. Some states have this capability, but many do not. This linked data could be a valuable data source for other important quality measures, especially if linked to other data sources such as newborn screening, early intervention services, etc.
- Although this is an important recognized quality measure and the rate is increasing in a direction that is opposite what is recommended, many cesareans are performed for medically indicated reasons. New quality measures and initiatives have been proposed in this arena and should be included along with this measure.

5	Childhood immunization status	Children who received 4 DTaP vaccinations, 3 IPV, 1 MMR, 2 Hib, 3 Hepatitis B, 1 VZV, and 4 pneumococcal conjugate vaccines on or before their second birthday (Composite 3; other composites are available)	Enrolled children who turn 2 yrs of age during the measurement year Continuous enrollment for 12 months prior to child's second birthday	H	B	4.9 million children ages 0-2 ²
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Comments:

<ul style="list-style-type: none"> State childhood immunization registries could be a potential data sources for this measure, and should strongly be considered. The availability, quality and timeliness of this data source do vary by state. These registries do not have sufficient immunization information on all children. However, requiring plans to submit their immunization data to state registries could adequately populate these registries for use for this purpose. Again, sufficient resources are needed to sustain the necessary infrastructure. Immunizations are important for all children, but especially for children with special medical conditions. We recommend this immunization measure be reported for these children. The additional measures would not be expensive if state childhood immunization registries were used assuming that information on special needs is collected by Health Plans. 						
6	Immunizations for adolescents	Number of people in the denominator who had one dose of meningococcal vaccine (MCV4) and one tetanus, diphtheria toxoid, and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoid vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.	Adolescents who turn 13 yrs of age during the measurement year Continuous enrollment for 12 months prior to the member's 13th birthday	H	B	10.1 million adolescents ages 13-18 ²
Comments: <ul style="list-style-type: none"> State childhood immunization registries could be a potential data sources for this measure, and should strongly be considered. The availability, quality and timeliness of this data source do vary by state. These registries do not have sufficient immunization information on all adolescents. However, requiring plans to submit their immunization data to state registries could adequately populate these registries for use for this purpose. Again, sufficient resources are needed to sustain the necessary infrastructure. Immunizations are important for all children, but especially for children with special medical conditions. We recommend this immunization measure be reported for these children. The additional measures would not be expensive if state childhood immunization registries were used assuming that information on special needs is collected by Health Plans. 						
7	Weight assessment for children/adolescents	Children in the denominator population who had evidence of Body Mass Index (BMI) documentation during the measurement year	Children 3-17 yrs of age who had an outpatient visit with a PCP or OB-GYN during the measurement yr Continuous enrollment—the measurement year Optional exclusion: pregnant women	H	D; ¹	31.9 million children ages 2-12 ²
Comments: <ul style="list-style-type: none"> In many states, schools provide the greatest potential source of information on height, weight, and body mass index. However, this identified information is currently protected by FERPA which inhibits the use of this information for this and other public health efforts. FERPA legislation would need to be revised to permit data use for public health surveillance and other health measurement efforts. Some childhood immunization registries include information on height, weight and body mass index. If linked to health plan data, this could also be an important source for information in those states. 						
8	Screening using standardized screening	Number of children screened for social and emotional development	Children ages 0-12 months, 12-24 months, or 24-36 months who had a WCV/other primary care	H	B	9.5 million ages 0-3 ² 14 million

	tools for potential delays in social and emotional development	with a standardized, documented tool or set of tools as part of a well child or other visit to primary care provider—3 rates (one for each age range in the denominator)	visit during the measurement yr who were enrollees in Medicaid/CHIP			ages 0-5 ²
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Comments:

- We strongly recommend that AHRQ and CMS adopt the measure, wording and specifications for this measures as submitted by the Child and Adolescent Health Measurement Initiative (CAHMI) and the National Committee for Quality Assurance (NCQA) to the National Quality Forum – State Level Measure of Developmental Screening in the First 3 Years of Life.¹ This measure is focused on general developmental screening as recommended by the American Academy of Pediatrics (AAP) in Bright Futures, 3rd Edition.
- There are limitations to this important measure as proposed, including the need for a clear definition of a standardized (and validated) screening tool as well as a tool that is age-appropriate. This specification can be easily incorporated into the existing measure language, and better captures the quality of care. Additional resources may be required to implement.
- Screening is only the entry step to care. A related measure that captures follow-up (by appropriate specialty care and within a designated time-frame) for possible delay is also needed for improving quality of care.

19	Annual number of asthma patients (≥ 1 year old) with ≥ 1 asthma related ER visit (S/AL Medicaid Program)	Number of children ≥ 1 year old in the denominator sample who had ≥ 1 ER visit(s) during the measurement year (March 1 through February 28th) where the primary diagnosis assigned on the claim was asthma	All children ≥ 1 yr old diagnosed with asthma or are on at least two short-acting beta adrenergic agents during the measurement year	A	C	2.7 million Medicaid-enrolled children ages 0-17 with asthma ⁴
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Comments:

- Consider adding hospitalizations due to asthma. AHRQ, CDC and the MA Division of Healthcare Finance and Policy consider childhood asthma hospitalizations to be preventable. Emergency visit for asthma could result from viral infections. However, almost no child should be hospitalization due to their asthma with proper treatment.

IV. Overall comments about new potential measures:

- Many quality measures are missing at key children life stages, especially those related to the leading causes of childhood mortality and morbidity in the United States. The literature supports that health care providers can play a key role in influencing these outcomes. We recommend that AHRQ and CMS consider additional measures are needed to cover these.
- Plan-specific and clinical measures must be viewed in the context of improving the overall health of children as well as health care services. This includes better understanding childhood, adolescent and family behaviors and health-related decisions as they impact child, adolescent, and community health. Health care plans and providers can influence these behaviors as well as support community-based prevention efforts. Better quantifying these behaviors and related prevention activities may ultimately improve health and reduce costs to private and public purchasers. Consideration should be given to potential data sources such as youth risk behavior surveys and school health data.

V. New potential measures

- Autism—We recommend that AHRQ and CMS develop a measure related to screening using standardized screening tools for autism. The American Academy of Pediatric Guidelines (Bright Futures, 3rd Edition) call for autism screening at 18- and 24 months.
- Short Interpregnancy Interval—We recommend the inclusion of proportion of deliveries with short Interpregnancy interval of less than 12 or 18 months. A short interpregnancy interval is one of the strongest and most consistent indicators of poor perinatal outcomes, including low birth weight, preterm birth, and small for gestational age. (Conde-Agudelo A. *JAMA*; 295: 1809-1823). This measure can readily be estimated by linking birth data with health plan eligibility data. This measure would capture access to the tools for effective control of fertility by women and men that supports healthy baby spacing. There are multiple aspects of high quality family planning care that are reflected in appropriate baby spacing including availability and enabling policies. Birth interval is use as a commonly used measure among Medicaid 1115 Waiver states.
- Newborn screening—We recommend two measures for this issue. One is the proportion of infants not receiving newborn screening (both blood and hearing) who receive follow up screening. The second is the proportion of infant with abnormal newborn screening (both blood and hearing) who receive follow up testing. Follow up screening and testing are major health care quality issues where public health agencies play a major role, but health care plans can play an important role in both follow screening and testing. This information can readily be reported by linking health plan eligibility data with state newborn screening data.
- Safe infant sleep behaviors—We recommend measures on safe infant sleep behaviors such as the proportion of infants less than 6 months who sleep predominantly on their back and the proportion of infant less than 6 months who do not sleep predominantly with others. These are major risk factors for Sudden Infant Death Syndrome and Sudden Unexpected Infant Death. Health care providers have been identified as the major influencer of these behaviors. These measures along with many other important maternal and child health indicators could be estimated by health plan if this data was linked to the Centers for Disease Control and Prevention's (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS). Many states could do this, but additional resources may be needed in increase the sample size.
- Breastfeeding—We recommend measures on the proportion of infants discharged from the hospital who are exclusively breastfeed. Breastfeeding decreases the risk of illnesses and related health care costs. Hospital and provider practices greatly influence breastfeeding practices. Such a measure would be beneficial. Several measurement sources are possible including PRAMS described in the recommendation above.
- Unintended Pregnancy— We recommend a measure on the proportion of live births born to women that is unintended. Unintended pregnancy has a major impact of infants including bonding, neglect, abuse, and more. Contraceptive providers have a major influence on contraceptive use and reducing unintended data. Several measurement sources are possible including PRAMS described in the recommendations above. The challenge would be eligibility duration on Health Plans especially if eligibility starts with pregnancy. However, this may change under health care reform.
- Medical home— We recommend that AHRQ and CMS place as a priority the development or enhancement of measures that focus on the medical home. A composite measure exists in the national survey of children's health and children with special health care needs and, we believe, is addressed to some extent in the Consumer Assessment of Health Plans. While it is very important to capture measures about the frequency of preventive health visits, we need to begin thinking about the quality of the content of those visits and the integration of preventive health with other aspects of the health care system. The medical home is core to care management and integration of services across a continuum of care.
- Sickle Cell Disease—We recommend the proportion of children who turn two with sickle cell disease who receive pneumococcal vaccination as recommended. Hemoglobinopathies include Sickle Cell Disease (SCD), the second

most prevalent condition among those identified through Newborn Screening program. The incidence of hospitalization and mortality from invasive pneumococcal disease are significantly higher in children with sickle cell disease than in the general pediatric population, hence the recommended penicillin prophylaxis and vaccination. Vaccine has made a major difference. (Adamkiewicz TV. Pediatrics. 2008 Mar; 121(3): 562-9.) Health Plans need to assure these vulnerable populations are receiving the necessary vaccinations. This information can be reported in some states by linking health plan eligibility data to state newborn screening and state immunization registries.

- Sickle Cell Disease—We recommend a future sickle cell disease measure: to reduce the proportion of hospitalizations due to preventable complications of sickle cell disease among children aged 9 years and under. A related measure is the proportion of children 9 years and under with more than 1 emergency department visit for pain crisis. Sickle Cell Disease is the second most prevalent condition among those identified through Newborn Screening program. Sickle cell disease is a hematological disorder that is manifested primarily by severe pain and chronic organ damage. Acute and chronic clinical manifestations of sickle-cell disease lead to significant healthcare utilization, especially of the emergency department. Seven states are in the process of implementing the sickle-cell disease surveillance via the RuSH (Registry and Surveillance of Hemoglobinopathies) grant. The linkage includes linking newborn screening results with other data sources such as hospital discharge, Medicaid, emergency department, that could be also used alone in order to assess the health care utilization. The linkage with newborn screening serves for following the same cohort of individuals identified through this program as having SCD while the latter (use of data sources alone) serves as a cross sectional assessment of those having the disease but not diagnosed by the newborn screening state program. Alternative approach by other states may be to calculate similar rates using Health Plan eligibility and encounter databases.
- Injuries (childhood bicycle and motor vehicle injuries)—We recommend AHRQ and CMS explore ways to measure the number one killer and reason for hospitalization among children. Evidence shows that health care providers can influence the behaviors that contribute to these injuries. Approaches are to estimate related measures by health care plans. We recommend the same effort for teen suicide and attempted suicide attempts
- Teen suicides or attempted suicides—We recommend a similar approach to measures for teen suicide and attempted suicide attempts as for the earlier injury recommendations. These would need to be define specific to potential Medicaid health plan services or interventions. This would be an important adolescent mental health measure.