Massachusetts Child Health Quality Coalition: Measure Development Results

Presented by: Ayesha Cammaerts & Janice Singer
Results Summary

• As a result of the modified Rand Delphi process we found eight new measures and one HEDIS measure had acceptable ratings for validity and feasibility.

• Acceptable measures incorporated all of the domains in the Care Coordination Framework.
RAND Delphi Method Workgroups

• The modified RAND Delphi Method has 2 groups: behavioral health and quality measurement experts to develop proposed measures for feasibility and validity (the pre-work group), and a multi-stakeholder group of experts to evaluate the measures based on expert opinion and literature (the selection committee).
MDW Process: Pre-Work Group

• Formed in December 2012
• Composed of behavioral health and quality measurement experts met 7 times and completed:
  • Review of care coordination framework
  • Working definition for behavioral health
  • Review of landscape of existing measures
  • Ranking of 75+ existing measures and review of multiple survey tools
  • Creation of measure alignment strategy
  • Draft of new measure concepts for areas of measure gaps in the care coordination framework
## Pre-Work Group Members

<table>
<thead>
<tr>
<th>Work Group</th>
<th>Organizational Affiliation</th>
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<tbody>
<tr>
<td>Kathy Jenkins MD, MPH (Co-Chair)</td>
<td>Chief Safety and Quality Officer, Boston Children’s Hospital (BCH)</td>
</tr>
<tr>
<td>Janice Singer MPH (Co-chair)</td>
<td>VP of Programs and Operations, Mass. Health Quality Partners</td>
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<tr>
<td>Richard Antonelli MD, MS</td>
<td>Integrated Care and Strategic Partnerships, BCH</td>
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<tr>
<td>Eugenia Chan MD, MPH</td>
<td>Developmental Medicine Center, BCH</td>
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<td>Kathy Coltin MPH</td>
<td>External Quality Data Initiatives at Harvard Pilgrim Health Care</td>
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<tr>
<td>Marguerite Dresser MS</td>
<td>Mass. Health Quality Partners</td>
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<td>Karen Hacker MD, MPH</td>
<td>Allegheny County Health Department; was Senior Medical Director, Public and Community Health for Cambridge Health</td>
</tr>
<tr>
<td>Constance Horgan ScD</td>
<td>Institute for Behavioral Health The Heller School at Brandeis</td>
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<tr>
<td>Roslyn Murov MD</td>
<td>Director of Outpatient Psychiatry Services, BCH</td>
</tr>
<tr>
<td>Michael Murphy EdD</td>
<td>Department of Psychiatry, Mass. General Hospital</td>
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</table>
(1) Needs assessment for care coordination and continuing care coordination engagement
- Family-driven, youth-guided needs assessment, goal setting
- Use standard process to assess care coordination needs (differs from clinical needs)
- Engage team, assign clear roles and responsibilities
- Develop authentic family-provider/care team partnerships; requires family/youth capacity building, professional skill building

(2) Care planning and communication
- Family and care team co-develop care plans
- Ensure communication among all members of the care team
- Monitor, follow-up, respond to change, track progress toward goals
- Workforce training occurs that promotes effective care plan implementation

Priorities/Comments:
- Establish process for co-developing care plans with active family participation; success will require workforce training that addresses effective communication techniques (listening skills, *Right Question, Teach Back*, health literacy principles).
- Put communication mechanisms in place to ensure all providers are on the same page.
- Having a care plan seen as effective vehicle to promote communication and ensure care team is on the same page, and track progress toward goals. Components should emphasize family/youth knowing danger signals, whom to call, outstanding to-do list (care coordination items being followed up, responsibilities). Must recognize changing health needs and family circumstances.

(3) Facilitating care transitions to/from inpatient settings; across ambulatory settings (PCPs, sub-specialists including behavioral health)
- Family engagement to align transition plan with family goals, needs
- Implement components of successful transitions (8 elements, incl receiving provider acknowledging responsibility)
- Ensure information needed at transition points is available

Priorities/Comments:
- Family participation fundamental; need for referral clearly understood, aligns with family goals, barriers to completing visit addressed.
- Ensure follow-up to primary care provider after referral visits; phased strategies to address follow-up to other members of the care team (including school/child care/community settings when appropriate).

(4) Connecting with community resources and schools
- Facilitate connection to MA family-run org/Family Partner
- Coordinate services with schools, agencies, payers
- Identify opportunities to reduce duplication of efforts in building knowledge of available community services

Priorities/Comments:
- System- and community-level opportunities to reduce duplication of efforts in building knowledge of available community services and training care coordinators and family partners.

(5) Transitioning to adult care
- Implement National Health Care Transition Center’s Six Core Elements of Health Care Transition (HCT)
- Teach/model self-care skills, communication skills, self-advocacy
Behavioral Health Care

Mental health care

Care for developmental delay and autism spectrum disorders

Substance use/abuse treatment
## Selection Committee Members

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<tr>
<td>Dr. Barry Sarvet</td>
<td>Bay State Chief of Psychiatry</td>
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<tr>
<td>Michael Murphy EdD</td>
<td>Mass. General Hospital Dept. Psychiatry</td>
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<tr>
<td>Dr. Kate Hobbs Knutson</td>
<td>MassHealth Associate Medical Director and Adult &amp; Child Psychiatry, South Boston Community Health Center</td>
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<tr>
<td>Dr. Deborah Allen</td>
<td>Director of Child, Adolescent, &amp; Family Health Bureau Boston Public Health Commission</td>
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<tr>
<td>Dr. Snehal Shah</td>
<td>Director of Office of Research and Evaluation Boston Public Health Commission</td>
</tr>
<tr>
<td>Dr. Lauren Mednick</td>
<td>Child Psychologist, Boston Children’s Hospital</td>
</tr>
<tr>
<td>Mary J. O’Brien RN PhD</td>
<td>Practicing School Nurse in Boston Public Schools and Founding Member of Mass. School Nurses Research Network</td>
</tr>
<tr>
<td>Julia Swartz MSW</td>
<td>Clinic Director Compass Medical</td>
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Quality Measure Selection: RAND Modified Delphi Method

*Purpose* is to evaluate quality measures by involving stakeholders and gaining expert opinion. No consensus required therefore minimizing bias from participants.

*Delphi Panel*: experts nominated by stakeholders who give anonymous ratings on validity and feasibility to the preliminary lesion specific QM proposed in 2 rounds of voting and discussion.

*QM scored (1-9) in 2 rounds*: 1st reject/modify QM with poor validity or feasibility and the 2nd to modify and re-rate the QM.
Validity Rating

• Adequate scientific evidence or expert opinion to support measure

• Compliance with measure confers significant health benefits

• Health systems/providers with higher levels of adherence are considered higher quality

• Health system/providers have significant control over determinants of adherence

• Validity score ranked between 1 and 9; 7-9 considered highly valid
Feasibility Ratings

• Information necessary to score measure is likely to be available or should be available in the average medical record

• Scores based on medical record data are likely to be reliable and unbiased

• Failure to provide adequate documentation is itself an measure of poor quality

• Feasibility score ranked between 1 and 9; scores of 4 to 9 considered acceptable
Final Set Quality Measures

Includes all measures scored with:

• Median validity score of $\geq 7$ and
• Median feasibility score of $\geq 4$ and
• Scored without disagreement according to the absolute deviation from the median score
# Measures Summary

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<td>Needs assessment for care coordination and continuing care coordination engagement</td>
<td>The percent of individuals 0-21 years of age with behavioral health diagnoses, who have, documented in their medical charts, a needs assessment for care coordination services, based on an assessment that used a standardized tool, for whom a care coordination plan was created with: family and child involvement and goals that have been set to meet their care coordination needs.</td>
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<td>Care planning and communication</td>
<td>The percent of primary care patients who are under the care or receiving care from a behavioral health provider whose primary care provider chart has a documented plan for follow-up of their behavioral health condition(s) linked to well child visits.</td>
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| Facilitating care transitions to/from inpatient settings; across ambulatory settings (PCPs, sub-specialists including behavioral health) | 1. The percent of pediatric patients, discharged from the ED with behavioral or mental health diagnoses, to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.  
2. Existing HEDIS Measure- The percent of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days |
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| Connecting with community resources and schools | 1. The percent of parents/caregivers with children who have behavioral health diagnoses and report that they were offered family-to-family support services to assist them, as assessed by a survey.  
2. The percent of children who have behavioral health diagnoses who have documentation in the primary care chart that they or their parents/family/care-giver were offered family-to-family support services to assist them.  
3. The percent of parents with children with behavioral health diagnoses who reported that they were offered a contact person or provider to help facilitate communication regarding care between schools, state agencies, and other community resources; serving as a central person supporting the care received across all domains, as assessed by a survey. |

| Transitioning to adult behavioral health care | 1. Percent of individuals 14-21 years of age with behavioral health diagnoses and that may require care into adulthood, that have documented in their primary care chart that they are included in their primary care practice’s registry or up-to-date list of individuals 14-21 years of age with behavioral health diagnoses.  
2. Percent of individuals who meet both of the following criteria: 1) they are included in the practices registry or up-to-date list of individuals 14-21 years of age with behavioral health diagnoses that may require care into adulthood and 2) have documentation in their behavioral care chart that is used at the point of care. |
Denominator Groups

**BROAD GROUP :**
Patients ages 0-21 with at least 2 claims for outpatient services or 1 ED or inpatient claim with BH as the primary diagnosis and/or service code

**SUB-GROUP A**
Patients from broad group with at least one additional complex chronic medical condition

**SUB-GROUP B**- Patients from broad group with a Serious Emotional Disturbance diagnosis as defined by US Federal Gov.
Denominator Definition

Used in 7 of 8 new measures

**Denominator Statement:** Individuals 0-21 years of age with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code

**Sub-group A** Those in the denominator that also have a chronic medical condition, defined as a physical condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as physical, developmental, or mental health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

**Sub-group B** Those in the denominator that also have Serious Emotional Disturbance (SED) defined by Individuals with Disabilities Education Act (IDEA) as follows:

“...a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.”

As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.
Next Steps

• Explore pilot testing plans and funding
  – Proposing a testing methodology
  – Assess cost of testing measures

• Write up final results for CMS/AHRQ and possible publication
  – Include details of literature, research, and lessons learned
Discussion

• Please share comments on the measures and general process results.
• Interest in measure testing and ideas are welcome
Appendix
Measure 1

Measure Description: The percent of individuals 0-21 years of age with behavioral health diagnoses, who have, documented in their medical charts, a needs assessment for care coordination services, based on an assessment that used a standardized tool, for whom a care coordination plan was created with: family and child involvement and goals that have been set to meet their care coordination needs.

Numerator Statement: Individuals who meet all of the following criteria: a) have documented in their medical chart a needs assessment for care coordination services in the measurement timeframe, b) based on an assessment that used a standardized tool, c) for whom a care coordination plan was created, d) with family and child involvement or patient if over 16, and e) with goals to meet their care coordination needs.

Denominator Statement: Individuals 0-21 years of age with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code. Sub-group A) Those in the denominator that also have a chronic medical condition, defined as a physical condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as physical, developmental, or mental health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years). Sub-group B) Those in the denominator that also have Serious Emotional Disturbance (SED) defined by Individuals with Disabilities Education Act (IDEA) as follows: “…a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:
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As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Data Source: Primary Care Provider Chart Review/Administrative Claims

Reporting: Each of the elements a) through e) will be reported on separately
Performance Assessment: Performance will be assessed by the eligible cases that meet all of the criteria: a) through e) in the numerator, and will be reported for each individual criterion.
Measure 3  
Measure Description: The percent of primary care patients who are under the care or receiving care from a behavioral health provider whose primary care provider chart has a documented plan for follow-up of their behavioral health condition(s) linked to well child visits.

Numerator Statement: The number of well-child visits with a plan for follow-up behavioral health care documented in the primary care provider chart.

Denominator Statement: All well child visits for patients 0-21 years of age with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code

Sub-group A) Those in the denominator that also have a chronic medical condition, defined as a physical health condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as physical health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

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Data Source: Primary Care Provider Chart Review/Administrative Claims
MEASURE 32 (NQF AND HEDIS MEASURE CURRENTLY)

Measure Description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days

Numerator:
• An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator:
• Discharges for members 6 years of age and older as of the date of discharge who were hospitalized for treatment of selected mental health disorders. Must be discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.
MEASURE 31

Measure Description: Percent of pediatric patients, discharged from the ED with behavioral or mental health diagnoses, to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements.

Numerator Statement: The number of patients who have documented in their medical chart that they or their caregivers(s) received a transition record at the time of ED discharge including, at a minimum, all of the following elements:

- Major procedures and tests performed during ED visit
- Principal diagnosis at discharge OR chief complaint
- Patient instructions
- Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care
- Updated medication list including new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each

Denominator Statement: Pediatric patients age 0-21 treated for behavioral or mental health conditions in the ED discharged from an ED to ambulatory care (home/self-care) or home health care.

Denominator Inclusions:
Behavioral or mental health conditions include anxiety disorders, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, bipolar disorder, depression, eating disorders, and schizophrenia.

Denominator Exclusions:
Patients who died or left against medical advice or discontinued care

Data Source: Emergency Department (ED) Chart Review
Measure 8
Measure Description: The percent of parents/caregivers with children who have behavioral health diagnoses and report that they were offered family-to-family support services to assist them as assessed by a survey.

Numerator Statement: The number of parents reporting yes to the survey question: “Were you offered family-to-family support services to assist you? (Yes/No)”.

Denominator Statement: Parents who answered a parent survey and have children 0-18 years of age, currently receiving behavioral health care, with at least 2 claims for outpatient behavioral health services or 1 ED or inpatient claim with behavioral health as the primary diagnosis and/or service code.

Sub-group A) Those in the denominator that also have a chronic medical condition, defined as a physical health condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as physical health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

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As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Definitions:
Family-to-family support services: Parent-to-parent support programs have become an important part of the service system for children with chronic health conditions. The 12- to 15-month programs provided informational, affirming, and emotional support to mothers of school-aged children with chronic illnesses. Support was provided by trained "veterans" (mothers who were raising or had raised children with similar conditions). Results indicate that each program reduced anxiety in high-risk mothers assigned to the experimental group compared to their counterparts in the control group (Ireys, Chernoff, Stein, DeVet & Silver, 2001).

Data Source: Parent Survey/Administrative Claims
**Measure 9**

**Measure Description:** The percent of children who have behavioral health diagnoses who have documentation in the primary care chart that they or their parents/family/care-giver were offered family-to-family support services to assist them.

**Numerator Statement:** The number of patients 0-21 years of age who have documented in their primary care chart that they or their parents/family/care-giver were offered family-to-family support services to assist them.

**Denominator Statement:** Patients 0-21 years of age, currently receiving behavioral health care, with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code.

Sub-group A) Those in the denominator that also have a chronic medical condition, defined as a physical health condition that is expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as physical health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

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**Data Source:** Primary Care Chart Review/Administrative Claims
**Measure 10**  
**Measure Description:** The percent of parents with children with behavioral health diagnoses who reported that they were offered a contact person or provider to help facilitate communication regarding care between schools, state agencies, and other community resources; serving as a central person supporting the care received across all domains, as assessed by a survey.

**Numerator Statement:** The number of parents reporting, “yes” to the question: “Were you offered a contact person or provider (include examples) who would facilitate communication about care between schools, state agencies and other community resources, serving as a central person supporting the care received across all domains? (Yes/No)”.

**Denominator Statement:** Parents who answered a parent survey and have children 0-18 years of age, currently receiving behavioral health care, with at least 2 claims for outpatient behavioral health services or 1 emergency department or inpatient claim with behavioral health as the primary diagnosis and/or service code  
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As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

**Data Source:** Parent Survey/Administrative Claims
Measure 24

Measure Description: Percent of individuals 14-21 years of age with significant behavioral health diagnoses and that may require care into adulthood that are documented in their primary care chart that they are included in their primary care practice’s registry or up-to-date list of individuals 14-21 years of age with behavioral health diagnoses.

Numerator Statement: The number of individuals who meet both of the following criteria: 1) they are included in the practices registry or up-to-date list of individuals 14-21 years of age with behavioral health diagnoses that may require care into adulthood and 2) have documented in their primary care chart that is used at the point of care.

Denominator Statement: Individuals 14-21 years of age who have a chronic condition, defined as a developmental or mental health condition expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as a developmental, or mental health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

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As defined by IDEA, emotional disturbance includes schizophrenia but does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

Definitions:

Practice registries: Clinic patient lists updated at least annually, and used for general use that have the capability of filtering or flagging adolescents 14-21 years of age with behavioral health diagnoses satisfy this metric.

Transition: The process of assessing needs and planning a change to adult-oriented health care.

Data Source: Primary Care Chart Review/Administrative Claims
Measure 26

Measure Description: Percent of individuals 14-21 years of age with significant behavioral health diagnoses that may require care into adulthood that are included in their behavioral health practice’s registry or up-to-date list of adolescents 14-21 years of age.

Numerator Statement: The number of individuals who meet both of the following criteria: 1) they are included in the practices registry or up-to-date list of individuals 14-21 years of age with behavioral health diagnoses that may require care into adulthood and 2) have documentation in their behavioral care chart that is used at the point of care.

Denominator Statement: Individuals 14-21 years of age who have a chronic condition, defined as a developmental or mental health condition expected to persist well into adult age range (>20 years) and in all likelihood will be lifelong, OR an episodic chronic condition, defined as a developmental, or mental health condition that is expected to last at least a year, have variable manifestations of severity, and result in use of health care resources above the level for a healthy child, and may not persist into the adult age groups (>19 years).

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Transition: The process of assessing needs and planning a change to adult-oriented health care.

Data Source: Behavioral Health Chart Review/Administrative Claims