

The Importance of the Pediatric Quality Measurement Program in Advancing Children's Health Care: A View From Children's Hospitals

Marlene R. Miller, MD, MSc; Ellen Schwalenstocker, PhD; Mark Wietecha, MSc, MBA

From the Department of Pediatrics, Johns Hopkins University, Baltimore, Md (Dr Miller); and Children's Hospital Association, Alexandria, Va (Dr Miller, Dr Schwalenstocker, and Mr Wietecha)

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Address correspondence to Marlene R. Miller, MD, MSc, Department of Pediatrics and Health Policy and Management, Johns Hopkins Children's Center, Armstrong Institute for Patient Safety and Quality, Johns Hopkins University, 200 N Wolfe St, Room 2094, Baltimore, MD 21287 (e-mail: mmille21@jhmi.edu).

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THE CHILDREN'S HEALTH Insurance Program Reauthorization Act (CHIPRA) of 2009 catalyzed the first significant national funding for filling gaps in pediatric quality measurement and reporting and remains a critical step forward for children's health care quality. Title IV of CHIPRA recognized the need for a robust set of measures across a full range of services, quality domains, care settings, and developmental stages. The Pediatric Quality Measurement Program (PQMP) was established to increase the "portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers and consumers."¹ Before CHIPRA, most national quality measurement and reporting initiatives were funded through the Medicare program and focused on adult care.

Quality measurement is fundamental as hospitals serving children work to achieve the 3-part aim of the National Quality Strategy: better health care, healthier people/communities, and affordable care. These hospitals serve infants, children, and adolescents requiring the breadth of health care services, including preventive care and intensive services for children with complex medical needs. Meaningful progress in better managing the nation's health care costs requires us to have a robust set of measures if we are to ensure the necessary access to high-quality care for those who need it most. As children's hospitals advance new models of care and anticipate value-based purchasing, robust measures enabling them to assess the quality and value of the care they provide are essential. The PQMP is critically important given that the hospital segment was largely unrepresented in the initial CHIPRA core set of measures for children in Medicaid and CHIP, primarily as a result of the lack of robust established measures for pediatric inpatient care. From the children's hospitals perspective, it is imperative to develop a full range of meaningful measures across the spectrum of health status in the population. This requires measures addressing basic primary care access and preven-

tion for all children to the tertiary and longer-term medical home access for the millions of children born with complex and chronic medical conditions.

CURRENT STATE OF REPORTING ON CHILDREN IN MEDICAID AND CHIP

Although the initial CHIPRA children's core measure set was an important beginning, it highlights the inadequacy of currently available measures and reporting infrastructure, which is compounded by voluntary and aggregate state reporting. In federal fiscal year 2011, 48 states reported on at least one of the core measures.² However, reporting was highly variable. Half of the states reported only on preventive health and ambulatory care measures, while only 1 state reported on central line-associated blood stream infections, the only measure providing a view into pediatric inpatient care.

The updated 2013 Children's Core Set of Health Care Quality Measures includes 26 measures, half of which address preventive care. Preventive care for children is surely important and is a cornerstone of pediatrics. This being said, we know hospital inpatient care accounted for almost 23% of health care spending for individuals under age 18 years in 2010.³ Among children requiring inpatient care is a subset of children with medical complexity, characterized by chronic and severe health conditions, substantial health service needs, major functional limitations, and high resource use. Of the approximately 33 million children covered by Medicaid, an estimated 2 million are classified as children with complex medical needs. This group accounts for approximately 10 times the cost per year on average compared to other children covered by Medicaid,⁴ and children's hospitals have seen substantial growth in the numbers of these children, given improvements in medical treatments. Yet few if any meaningful measures currently exist with which to assess and improve the care this

resource-intensive group of children receive. New and cross-cutting meaningful measures are essential if we are to truly improve the health and health care of all our nation's children, including those with medically complex conditions.

EVOLVING MEASUREMENT NEEDS

Measurement science must evolve along with efforts to improve quality and the ways in which care is delivered and financed. Experts have suggested priority areas including health outcomes, care coordination, patient and caregiver engagement, structural measures, and measures that combine quality and resource use as well as investment in the basic science of measurement.^{5,6} Despite this concurrence, a National Quality Forum report highlighted a relative lack of outcomes measures as compared to process measures and underrepresentation of cross-cutting areas in the portfolio of endorsed measures for both children and adults.⁷ The measures required to drive transformational improvement in our systems of care are simply not in place, especially for children.

The PQMP fills a critical role in the evolution of measurement science. As illustrated in this commentary, the 7 centers of excellence (COEs) funded through PQMP are working on leading-edge measure concepts, both cross-cutting and condition specific. The focus areas assigned to the centers are highly relevant, align with the priorities described above, and reflect the spectrum of care provided to children, from high-risk obstetrics and neonatal intensive care unit care to transitions to adult-focused care.

Although it is not possible to fully describe the work of the COEs here, we offer a few examples of measures of particular interest to children's hospitals and the nation in assessing the state of health care for children. These include the following: measures of care coordination for children with special health care needs; transitions between settings of care; pediatric hospital experience of care; patient-reported outcomes measures; a value framework linking outcomes measures and cost; and measures related to clinical effectiveness for specific conditions, including septicemia and sickle cell disease. As they work to address these measures, a consistent challenge faced by the COEs is lack of scientific evidence available in the literature. As a result, the PQMP is making an important contribution in identifying research priorities, establishing consensus where strong evidence does not exist, and advancing the science and methodology of quality measurement.

FUTURE NEEDS

Several things must happen in order for the intent of Title IV to be fully realized. First, sustained funding and attention are essential once the initial funding is expended in early 2015. As a result of PQMP, important infrastructure for developing multistakeholder input and specifying and testing pediatric measures has been built. It is critical to provide continued support for this carefully built infrastructure

as well as for ongoing measure endorsement and maintenance.

Second, state reporting capability should not be a limiting factor in the development and use of measures that "taken together, can be used to estimate the overall national quality of health care for children."¹ Financial pressures limit the degree to which states are able to report on measures, especially those measures requiring family reports or medical record data. Yet these types of measures are sorely needed by providers, payers, and consumers. Consideration also should be given to requiring states to report on core measures, in turn resulting in enhanced capability to estimate quality at a national level. Without consistent measurement and reporting, hospitals and other providers will be subject to a cacophony of measures from other insurers, and parents will be left without comparable information to engage in their child's care.

Third, a consistent data collection mechanism with centralized analytic capability is needed to ensure measures are collected and reported consistently, can be accessed at the appropriate level of analysis (eg, by hospital or health plan), and can be viewed publicly as appropriate. Although technical assistance and a reporting template for the core measures are provided through the Centers for Medicare and Medicaid Services (CMS), measures are reported at the aggregate state level and may include deviations from the technical specifications. Investment should be made in the development of a centralized data warehouse such as the Quality Improvement Organization Clinical Data Warehouse, which enables hospital data to be uploaded for various CMS programs.

Although no one can predict the future with certainty, all indications suggest continued movement toward aligning payment incentives with quality performance. Combined with innovation in care delivery systems and the imperative to improve the quality of care while reducing costs, children's hospitals want to be ahead of the curve with valid measures that reflect critical aspects of the care they deliver to the children they serve. Quality measurement—and the PQMP in particular—are essential in achieving this goal.

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