

# Communication of Weight Classification for Children Who Are Overweight or Obese

## Section 1. Basic Measure Information

### 1.A. Measure Name

Communication of Weight Classification for Children Who Are Overweight or Obese

### 1.B. Measure Number

0241

### 1.C. Measure Description

**Please provide a non-technical description of the measure that conveys what it measures to a broad audience.**

This measure assesses the percentage of children, ages 2 through 17 years, with a body mass index (BMI)  $\geq 85$ th percentile, who had documentation of communication of weight classification at an outpatient care visit during the measurement year. A higher proportion indicates better performance.

Obesity in children is associated with a broad spectrum of serious health issues, including obstructive sleep apnea, asthma, nonalcoholic fatty liver disease, type 2 diabetes mellitus, depression, orthopedic problems, and skin conditions (Barlow, 2007). While childhood obesity rates have stabilized over the past decade, the percentage of young children and adolescents who are overweight or obese remains high (Ogden, Carroll, Kit, et al., 2014). For the 2011-2012 period, nearly 32 percent of children in the United States were reported to be either overweight or obese (having a BMI  $\geq 85$ th percentile on sex-specific age-for-growth charts), and 17 percent were obese (having a BMI  $\geq 95$ th percentile) (Ogden, et al., 2014).

Family awareness of excess weight in a child is an essential first step toward making healthy changes that support appropriate weight levels. However, research shows that providers often do not discuss weight issues with parents of overweight/obese patients or they communicate in a way that parents do not recall (Perrin, Cockrell-Skinner, Steiner, 2012). (Note, here and elsewhere in this report, the word “parent” is inclusive of many caregivers, including biological parents, legal guardians, or other family members who are primary caregivers.) If healthcare providers discuss weight with families in a timely, informative, and supportive manner, they can foster the confidence and skills necessary for parents and children to address dietary and physical activity behaviors (Huang, Becerra, Oda, et al., 2007). Many issues exist that make these discussions difficult: for clinicians, lack of familiarity with guidelines, too little support and time in the clinic, concerns about stigmatization, and parental misperceptions about normal versus overweight in their own children (Dietz, Robinson, 2005; Doolen, Alpert, Miller, 2009; Klein, Sesselberg, Johnson, et al., 2010). Families are crucial partners in addressing weight issues, and

clinicians are in an excellent position to provide appropriate guidance. Improving the frequency and quality of these conversations is an essential first step toward helping children reach and maintain a healthy weight.

This measure uses medical record data to calculate the percentage of eligible children who had documentation of communication of weight classification.

### **1.D. Measure Owner**

The Quality Measurement, Evaluation, Texting, Review, and Implementation Consortium (Q-METRIC).

### **1.E. National Quality Forum (NQF) ID (if applicable)**

Not applicable.

### **1.F. Measure Hierarchy**

**Please note here if the measure is part of a measure hierarchy or is part of a measure group or composite measure. The following definitions are used by AHRQ's National Quality Measures Clearinghouse:**

- 1. Please identify the name of the collection of measures to which the measure belongs (if applicable). A collection is the highest possible level of the measure hierarchy. A collection may contain one or more sets, subsets, composites, and/or individual measures.**

This measure is part of the Q-METRIC High BMI in Children Follow-up Measures collection.

- 2. Please identify the name of the measure set to which the measure belongs (if applicable). A set is the second level of the hierarchy. A set may include one or more subsets, composites, and/or individual measures.**

Not applicable.

- 3. Please identify the name of the subset to which the measure belongs (if applicable). A subset is the third level of the hierarchy. A subset may include one or more composites, and/or individual measures.**

Not applicable.

- 4. Please identify the name of the composite measure to which the measure belongs (if applicable). A composite is a measure with a score that is an aggregate of scores from other measures. A composite may include one or more other composites and/or individual measures. Composites may comprise component measures that can or cannot be used on their own.**

Not applicable.

## **1.G. Numerator Statement**

The eligible population for the numerator is the number of children, ages 2 through 17 years, with a BMI  $\geq$ 85th percentile, who had documentation of communication of weight classification at an outpatient care visit during the measurement year (January 1-December 31).

Communication of weight status is defined as evidence in the medical record of a letter, telephone call, email message, or face-to-face discussion with a child's parent/guardian (mother, father, or primary caregiver) about the child's weight status. For documenting communication, terms used could include: overweight, obese, unhealthy weight, excess weight, heavy. Codes to identify outpatient care visits are listed in Table 1 (see Supporting Documents).

## **1.H. Numerator Exclusions**

1. Inpatient stays, emergency department (ED) visits, and urgent care visits are excluded from the calculation.
2. A diagnosis of pregnancy during the measurement year excludes the patient from the calculation.

## **1.I. Denominator Statement**

The eligible population for the denominator is the number of children, ages 2 through 17 years, with a BMI  $\geq$ 85th percentile, who had an outpatient care visit during the measurement year (January 1- December 31). Codes to identify outpatient care visits are listed in Table 1 (see Supporting Documents).

## **1.J. Denominator Exclusions**

1. Inpatient stays, ED visits, and urgent care visits are excluded from the calculation.
2. A diagnosis of pregnancy during the measurement year excludes the patient from the calculation.

## **1.K. Data Sources**

**Check all the data sources for which the measure is specified and tested.**

Paper medical records.

**If other, please list all other data sources in the field below.**

Not applicable.

## **Section 2: Detailed Measure Specifications**

Provide sufficient detail to describe how a measure would be calculated from the recommended data sources, uploading a separate document (+ Upload attachment) or a link to a URL. Examples of detailed measure specifications can be found in the CHIPRA Initial Core Set Technical Specifications Manual 2011 published by the Centers for Medicare & Medicaid Services. Although submission of formal programming code or algorithms that demonstrate how a measure would be calculated from a query of an appropriate electronic data source are not requested at this time, the availability of these resources may be a factor in determining whether a measure can be recommended for use.

Detailed measure specifications are provided; please see the Supporting Documents.

## **Section 3. Importance of the Measure**

In the following sections, provide brief descriptions of how the measure meets one or more of the following criteria for measure importance (general importance, importance to Medicaid and/or CHIP, complements or enhances an existing measure). Include references related to specific points made in your narrative (not a free-form listing of citations).

### **3.A. Evidence for General Importance of the Measure**

Provide evidence for all applicable aspects of general importance:

- Addresses a known or suspected quality gap and/or disparity in quality (e.g., addresses a socioeconomic disparity, a racial/ethnic disparity, a disparity for Children with Special Health Care Needs (CSHCN), a disparity for limited English proficient (LEP) populations).
- Potential for quality improvement (i.e., there are effective approaches to reducing the quality gap or disparity in quality).
- Prevalence of condition among children under age 21 and/or among pregnant women.
- Severity of condition and burden of condition on children, family, and society (unrelated to cost).
- Fiscal burden of measure focus (e.g., clinical condition) on patients, families, public and private payers, or society more generally, currently and over the life span of the child.
- Association of measure topic with children's future health – for example, a measure addressing childhood obesity may have implications for the subsequent development of cardiovascular diseases.
- The extent to which the measure is applicable to changes across developmental stages (e.g., infancy, early childhood, middle childhood, adolescence, young adulthood).

## **Importance**

Childhood overweight and obesity are recognized as major medical and public health problems associated with serious medical complications over the life course, including conditions such as type 2 diabetes, metabolic syndrome, and hypertension (Speiser, Rudolf, Anhalt, et al., 2005). As a result, early screening and identification of weight status in children is critical for both prevention and treatment of childhood overweight and obesity. Primary care providers measure weight and height at yearly visits throughout childhood and can calculate BMI by dividing weight by height squared. Overweight is defined as a BMI percentile of the 85th to 94th percentile, and obesity is defined as a BMI percentile  $\geq 95$ th percentile on sex-specific age-for-growth charts (Barlow, 2007). Guidelines suggest that patients in the overweight category receive counseling about prevention; those who are obese are quite likely to have obesity-related health risks and should be encouraged to work on weight control practices (Barlow, 2007).

## **Prevalence of Obesity and Unhealthy Weight in Children**

Significant increases in the prevalence of obesity among U.S. children across both sexes were seen in the 1980s and 1990s (Ogden, Carroll, Kit, et al., 2012). For the 2011-2012 period, nearly 32 percent of children in the United States were reported to be overweight or obese (having a BMI  $\geq 85$ th percentile), and at least 17 percent were obese (having a BMI  $\geq 95$ th percentile) (Ogden, et al., 2014). At the population level, this increase in prevalence is too rapid to be a genetic shift. Rather, changes in eating and physical activity behaviors are affecting the intake and expenditure of energy, resulting in overweight and obesity (Barlow, 2007).

## **Cost of Obesity and Unhealthy Weight in Children**

Excess weight in young people creates great economic burden. Children who are obese are approximately three times as expensive for the healthcare system as the average insured child, and children diagnosed with obesity are two to three times as likely to be hospitalized as those who are not obese (Marder, Chang, 2006). In a study by Wang and colleagues, the authors used projected overweight/obesity prevalence and national estimates of per capita excess healthcare costs of overweight/obesity to estimate that healthcare costs attributable to overweight/obesity in the entire U.S. population would reach between \$861 and \$957 billion by 2030, accounting for 16-18 percent of U.S. healthcare costs (Wang, Beydoun, Liang, et al., 2008).

## **Pathology and Severity of Obesity and Unhealthy Weight in Children**

Children gain excess weight for many reasons. There is a clear genetic component to obesity: conditions for early humans were stressful, making storage of fat advantageous (Speiser, et al., 2005). Hormones such as leptin, ghrelin, and adiponectin influence appetite, satiety, and fat distribution; they are key metabolic mechanisms that can influence physiologic risk (Barlow, 2007). In those who are genetically predisposed to obesity, behavior and environment influence its development (Barlow, 2007). Currently, genetic susceptibility to obesity is influenced by an environment rife with fast food, processed foods, sugar-sweetened beverages, and easy opportunities for meals eaten outside the home (White House Task Force, 2010). Compounding unhealthy food choices is a noticeable decrease in physical activity for children, as schools cut physical education classes, and community design promotes driving over walking and biking (White House Task Force, 2010). Screen time is another contributor to obesity, as children spend increasing amounts of time engaged with television, video games, smart phones, tablets, and

computers. Screen time replaces exercise, encourages consumption of advertised foods, and affects sleep quality, which itself is linked to an increased risk of obesity (White House Task Force, 2010).

Medical issues associated with obesity affect almost every organ of the body, though some conditions are without symptoms and signs (Barlow, 2007). Obese children are more likely to suffer from respiratory issues such as disordered breathing (Wing, Hui, Pak, et al., 2003), which can lead to right ventricular hypertrophy and pulmonary hypertension, as well as inattention, poor academic performance, and enuresis (Barlow, 2007). Asthma also occurs more frequently among children who are obese (Barlow, 2007). Gastrointestinal problems include nonalcoholic fatty liver disease (NAFLD), which is related to both obesity and diabetes (Barlow, 2007); gallstones (Kaechele, Wabitsch, Thiere, et al., 2006); and gastroesophageal reflux disease and constipation, which are worsened by obesity (Barlow, 2007).

Obese children are more likely to have endocrine disorders such as abnormal glucose metabolism (sometimes called pre-diabetes), which indicates higher risk for the development of diabetes (Li, Ford, Zhao, et al., 2009); type 2 diabetes mellitus, polycystic ovary syndrome; and hypothyroidism (Barlow, 2007). Cardiovascular problems for overweight/obese children include dyslipidemia (Lamb, Ogden, Carroll, et al., 2011) and hypertension (Barlow, 2007). Orthopedic problems include Blount disease (a visible bowing of the lower extremities), slipped capital femoral epiphysis, and an increased risk of fractures, musculoskeletal pain, and orthopedic problems (Dietz, Gross, Kirkpatrick Jr, et al., 1982; Manoff, Banffy, Winell, 2005). Skin conditions include acanthosis nigricans, a chronic irritation and infection in the folds of the skin (Nguyen, Keil, Russell, et al., 2001). Metabolic syndrome, a cluster of concurrent conditions (abnormal triglycerides, large waist circumference, and high blood pressure) that increase the risk of heart disease, stroke, and diabetes is not yet defined in children (Speiser, et al., 2005). However, among severely obese children, the risk of developing metabolic syndrome has been estimated at 50 percent (Weiss, Dziura, Burgert, et al., 2004).

Children who are obese also contend with psychiatric problems, including depression, anxiety, and eating disorders (Barlow, 2007). One study found that among female adolescents who were obese, patterns of observation showed more adverse social, educational, and psychological correlates compared with their non-obese peers (Faulkner, Neumark-Sztainer, Story, et al., 2001). Children who are obese may also be at risk for academic difficulties, alcohol and tobacco use, premature sexual behavior, inappropriate dieting practices, and physical inactivity (Daniels et al., 2009). Increasing weight is associated with decreasing health-related quality of life, lower body satisfaction, and lower self-esteem. Children who are overweight experience more teasing and are vulnerable to bullying (Daniels, Jacobson, McCrindle, et al., 2009). Children share society's negative opinions about those who are overweight or obese, regardless of their own weight status or sex (Speiser, et al., 2005). Their perceptions of obesity emphasize laziness, selfishness, lower intelligence, social isolation, poor social functioning, and low levels of perceived health, healthy eating, and activity. Children as young as 5 years of age are aware of their own levels of overweight, which affects their perceptions of appearance, athletic ability, social competence, and self-worth (Speiser, et al., 2005). Research has also shown that children diagnosed with obesity are much more likely to be diagnosed with mental health disorders or

bone and joint disorders than children who are not obese; they are also two-to-three times as likely to be hospitalized as those who are not obese (Marder, Chang, 2006).

Being overweight or obese in early life also has implications for a child's future health. First, for a child with a BMI above the 85th percentile, medical risks include future or persistent obesity (Barlow, 2007, Daniels, et al., 2009). The risk of an obese child becoming an obese adult is 25 percent at age 6 years, increasing to 75 percent during adolescence (Baker, Farpour-Lambert, Nowicka, et al., 2010). Being overweight or obese in childhood and adolescence is also associated with increased risk of premature mortality and comorbidities in adulthood. A 2011 systematic review reports a significant association between child and adolescent overweight/obesity and premature mortality, with hazard ratios ranging from 1.4 to 2.9 (Reilly, Kelly, 2011). In addition, being overweight or obese as a child or adolescent is significantly associated with increased risk of cardiometabolic morbidity (including diabetes, hypertension, heart disease, and stroke) in later life, with hazard ratios ranging from 1.1 to 5.1, as well as increased risk of asthma in adulthood and polycystic ovary syndrome in adult women (Reilly, Kelly, 2011). Obesity in adolescence is associated with negative self-image that persists into adulthood (Dietz, 1998). These children are also at long-term higher risk for chronic conditions such as breast, colon, and kidney cancer; musculoskeletal disorders; and gall bladder disease (Daniels, et al., 2009). Childhood obesity contributes to a significant and increasing burden of chronic disease, rising healthcare costs, disability, and premature death.

Given the vulnerability of obese children to serious physical and emotional complications, the case for prevention and treatment of pediatric obesity is irrefutable (Speiser, et al., 2005). Reducing childhood obesity can only be achieved through a comprehensive and coordinated effort that includes a range of multidisciplinary strategies (Daniels, et al., 2009). The goals of treatment are, first, to restore the balance between energy intake and expenditure, usually through a decrease in energy consumption and an increase in energy expenditure (Daniels, et al., 2009; Speiser, et al., 2005). Then, over the longer term, the goal shifts to reducing BMI and reversing or preventing short- and long-term comorbidities (Speiser et al., 2005).

It is understandable for providers to feel overwhelmed in dealing with obesity given the entrenched environmental forces that have contributed to the rise of unhealthy eating habits and sedentary behavior. Clinicians, however, can help improve outcomes for their patients by identifying problems early, helping families create positive home environments, and providing structured guidance to overweight and obese children and their families (Barlow, 2007). Successful obesity treatment improves long-term physical health through the development of lasting healthy lifestyle habits. For some children, these changes will be enough to induce weight loss or maintenance during growth periods. For others, further work will be needed. But developing and keeping healthy eating and exercise habits, regardless of weight loss, is important because of the long-term health benefits. Even slowed weight gain during growth periods will result in lower BMI percentiles (Barlow, 2007).

### **Outcomes of Communicating Weight Classification for Children Who Are Overweight**

Once a provider has assessed a child's BMI percentile and documented the appropriate weight classification, it is essential to address unhealthy weight by communicating with patients and

families. Acknowledging excess weight and its consequences is the first step in addressing obesity (Jeffery, Voss, Metcalf, et al., 2005). In fact, the very diagnosis of obesity is associated with improved obesity management (Perrin, et al., 2012). Pediatricians who screened patients and documented BMI were more likely to provide counseling about achieving a healthy weight status. Talking about overweight in children is the first step to providing ongoing, consistent, and supportive treatment to address potential health consequences. These steps often take the form of developing healthier eating habits and finding consistent opportunities for regular physical exercise. Primary care providers are in an excellent position to help families by promoting healthy perceptions regarding weight through regular discussion of a child's status. Likewise, parents are essential partners in efforts to address obesity as a health problem (Jeffery, et al., 2005). It is important to support the effectiveness of this provider-family relationship through thoughtful communications. Clinicians can help in fostering key parental confidence and encourage involvement in appropriate steps toward weight reduction and maintenance (Huang, et al., 2007).

This measure indicates documentation of BMI percentile for children ages 2 through 17 years at an outpatient visit within the measurement year. The measure does not change across developmental stages.

## **Performance Gap**

### **Counseling Rates Are Low**

Despite the clear benefits of counseling families about their child's weight status, many parents are not getting the message. In one study among children with a BMI  $\geq$ 85th percentile, only 22 percent of parents reported being told their child was overweight, and only 58 percent of parents of very obese children recalled being told of their child's weight status (Perrin, et al., 2012). Other studies report similarly low numbers. Lazorick and colleagues found that documentation of counseling regarding nutrition and physical activity was rare: 16 percent for children ages 3-5 years and 7 percent for ages 13-16 years (Lazorick, Peaker, Perrin, et al., 2011). Many of the overweight adolescents in this study already had comorbidities seen more frequently in adults. A third study reported a somewhat better rate of 51 percent for frequency of diet, exercise, and weight reduction counseling, but its authors noted the rate was still inadequate and did not address the depth or quality of counseling (Patel et al., 2010). Yet another study found that among overweight children, ages 2-19 years (or their parents), only 37 percent reported having ever been told by a provider that they were overweight (Ogden, Tabak, 2005). Among those ages 2-5 years, the rate was 17 percent, and from there it rose steadily: 33 percent for children ages 6-11 years; 40 percent for ages 12-15 years; and 52 percent for the oldest group, ages 16-19 years.

Low rates of discussion are prevalent but unacceptable. Children and families need help in addressing unhealthy weight. By the time children are of school age, they are already responding to environmental cues, not satiety, in deciding what they want to eat (Rolls, Engell, Birch, 2000). By the age of 5 years, the amount of food offered influences how much a child eats; in younger children (age 3½ years), the amount of food presented did not affect the amount consumed. As children develop, food intake is affected by social, cultural, and environmental factors (Rolls, et al., 2000). Early recognition of this developmental change is important to helping children learn good habits.



## **Clinicians Need Educational and Administrative Support**

Low rates of counseling stem from many sources. In a study by Klein and colleagues (2010), practicing pediatricians said they lacked the time to counsel patients about weight; found counseling alone to provide poor results; and noted that simple diet and exercise recommendations would be helpful. The intensity of what was needed from them to address obesity in children, many pediatricians felt, was beyond their capability as primary care providers (Barlow, 2007; Klein, et al., 2010). The fact that clinicians feel at a loss for dependable guidance is unsurprising. Science has lagged behind the obesity epidemic, leaving many gaps in evidence-based recommendations (Barlow, 2007). Randomized, controlled clinical trials have not been conducted to prove or disprove the effect of certain behaviors on weight control in obese children, and primary care systems have often been ineffective in developing processes to implement guidelines to assess children and adolescents who are overweight or obese (Barlow, 2007). Well-defined and validated preventive and therapeutic interventions for children and families are simply lacking (Daniels, et al., 2009), and public policy has not kept up (Speiser, et al., 2005).

Awareness of guidelines, often achieved through continuing medical education, and access to dependable tools for measurement and counseling, such as community resources to promote good nutrition and exercise, are helpful strategies for many clinicians. Providers who were familiar with guidelines for the assessment, prevention, and treatment of obesity reported higher self-efficacy and felt comfortable discussing weight (Klein, et al., 2010). It is interesting to note that one study found that pediatricians were more likely than family physicians to provide obesity-related behavioral counseling or guidance or counseling about obesity (Huang, Borowski, Liu, et al., 2011). One possible reason, the authors suggest, is that training for pediatricians may place greater emphasis on developmental issues.

Administrative pressure to keep patient visits brief can make the investment of time to counsel patients about obesity difficult. One answer to this problem is collaboration with other healthcare professionals, such as nurses, registered dietitians, or behavioral and exercise specialists. The use of specially developed tools and technology has also been reported to be of help (Huang, et al., 2011). Use of a simple toolkit that guided provider communication about weight and helped parents learn to correctly assess their children's BMI status resulted in short-term improvements in dietary and physical activity behaviors (Perrin, Jacobson, Vann, et al., 2010). These results (a reduction in the amount of time spent watching television and fewer sweet beverages consumed) showed that thoughtfully designed materials could help make the clinic an effective place to address short-term behavior change.

Office systems should be designed to track overweight and obese children, better supporting those working to manage their condition (Barlow, 2007). Offices should have the right equipment to document BMI consistently and accurately. This includes reliable scales for infants and children, recumbent infant length boards, and wall-mounted stadiometers. All equipment should be regularly calibrated. Likewise, staff must know how to accurately measure weight and height, calculate BMI, and plot the measures on growth curves. Further, chart audits can help make routine collection of BMI a standard practice by assessing baseline practices, setting goals for improvement, and then measuring improvement over time (Barlow, 2007). Use of color-

coded BMI charts in some clinics has led to improved reports of BMI discussion, suggesting the importance of this tool (Perrin, et al., 2010).

### **Discussions About Weight Are Associated with Uncomfortable Emotions**

In a society that projects mixed messages about food consumption and body image, the weight discussion itself is an uneasy assignment for some providers. Clinicians have been found to be reluctant to discuss weight issues in very young patients and more likely to discuss weight in those who are most overweight (Ogden, Tabak, 2005). Similarly, recall has been found to be better among the parents of older children, suggesting that providers need to improve their communication strategies regarding younger children (Perrin, et al., 2012). Parents interpret provider nonchalance about excess weight in young children as a barrier to making improvements in lifestyle habits. Yet, it is the families of very young overweight children who could most benefit from addressing weight issues early (Ogden, Tabak, 2005). The fact that recall rates are low, especially among younger children, suggests that clinicians are not explaining weight issues in a way that helps parents grasp and remember their child's weight status and related issues (Perrin, et al., 2012).

Providers say they are reluctant to discuss weight with families for a variety of reasons: they do not want children to feel stigmatized; they are concerned that parents will feel blamed; and they fear discussion will trigger an eating disorder or encourage poor self-concepts (Dietz, Robinson, 2005). Indeed, the adolescent experience of obesity has been associated with adverse social and educational experiences (Faulkner, et al., 2001). Findings suggest that not meeting weight and body shape ideals that are culturally pervasive is associated with social and psychological risks (Faulkner, et al., 2001).

### **Parents Often Misjudge Their Child's Weight**

Parent misperceptions about weight are also an impediment to clear communication about weight status. Several studies have shown that parents are poor judges of overweight (Doolen, et al., 2009; Huang, et al., 2007; Jeffery, et al., 2005; Perrin, et al., 2010, 2012). Jeffery and colleagues (2005) found that parents were poor at recognizing when they themselves were overweight and when their children were. Huang and colleagues (2007) noted a tendency among parents to misperceive what is a normal weight for younger children, and Perrin and colleagues (2010) reported that many parents thought their overweight child was of a healthy weight. Likewise, work by Doolen and colleagues (2009) showed that parents were more likely to correctly assess the weight status of normal versus overweight children and more likely to assess a daughter as overweight than a son. These tendencies potentially set up disordered eating in girls and untreated health issues in boys. Reasons for misperception may include denial; reluctance to admit there is a problem; or desensitization, as overweight is becoming the new normal and more accepted (Jeffery, et al., 2005); and, because excess weight seems normal, clinical labels are less likely to motivate change. Parents have also reported distrust of growth charts, a reluctance to label their children, and the belief that baby fat is different from adult fat (Doolen, et al., 2009).

It is important to help parents accurately assess their children's weight status: parental involvement is key to weight reduction and maintenance in children, and parental recognition is also associated with their readiness to take action (Huang, et al., 2007). Any missed opportunities to correctly assess weight mean that treatment opportunities are lost, and changes cannot be

implemented (Doolen, et al., 2009). Parents with an accurate perception of their child’s weight status are more ready to make changes around weight-related behaviors. Communicating with parents about weight status helps make parental changes more effective (Perrin, et al., 2012). In fact, research suggests that families can handle the facts about excess weight. A study in the United Kingdom designed to provide weight measurement and feedback to families in a school setting, communication about weight specifics was acceptable to a majority of families (Grimmett. Croker, Carnell, et al., 2008); 50 percent of parents subsequently reported positive changes in health behaviors, and 65 percent of parents were in favor of weight feedback on a regular basis. However, because as girls get older their self-esteem related to their bodies decreases, care should be taken in how feedback about weight is given; ample opportunity for discussion should be provided.

### **Reimbursement Can Be a Challenge**

Providers have reported that lack of reimbursement is a barrier to care for children who are obese (Barlow, 2007). Important gaps exist between prevention and treatment of childhood obesity and what is covered by health insurance (Daniels, et al., 2009). Other challenges include program recruitment and retention, financing, apathy at the policy and clinical levels, and variation in the priority placed on childhood obesity (Daniels, et al., 2009).

Unlike smoking where there is no safe level of use, food is not deadly; everyone needs to eat every day. Because of this, the public health response has focused on strategies that rely on individuals changing their behavior. However, the food industry’s substantial resources to influence what people eat make this an ineffective strategy (Daniels, et al., 2009). Encouraging collective responsibility for the availability of healthy foods and the value of physical exercise will better support individual efforts at successful weight management.

### **3.B. Evidence for Importance of the Measure to Medicaid and/or CHIP**

**Comment on any specific features of this measure important to Medicaid and/or CHIP that are in addition to the evidence of importance described above, including the following:**

- **The extent to which the measure is understood to be sensitive to changes in Medicaid or CHIP (e.g., policy changes, quality improvement strategies).**
- **Relevance to the Early and Periodic Screening, Diagnostic and Treatment benefit in Medicaid (EPSDT).**
- **Any other specific relevance to Medicaid/CHIP (please specify).**

Communication of weight status falls under the “screening” portion of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in Medicaid. The EPSDT benefit requires States to cover preventive services for children, which includes services necessary to prevent and treat obesity. The health education component of this mandate provides an opportunity for clinicians to discuss health concerns regarding weight and nutrition with the child and/or the parent or guardian. Necessary medical services can be covered by Medicaid under the EPSDT benefit. There is, however, considerable variability in coverage among the States. In a 2010 report to Congress, Preventive and Obesity-Related Services Available to Medicaid Enrollees, the Department of Health and Human Services (HHS) states, “CMS will

encourage States to include specific information on the standards of practice related to obesity prevention and treatment in their [State Medicaid] provider manuals.” Medicaid and the State Children’s Health Insurance Program (CHIP) can help improve access to preventive screenings and interventions (HHS, 2010). Through provisions in the Affordable Care Act, CMS can work with the public health community to prevent and treat obesity (HHS, 2010).

One in five children is covered by Medicaid or CHIP, and many others are eligible but do not receive services because parents are unaware of their eligibility (Daniels, et al., 2009). The number of children dependent on Medicaid is important, as the burden of the obesity epidemic disproportionately affects them. Nationally, 43.2 percent of children with public insurance are overweight or obese versus 27.3 percent of children with private insurance (National Initiative for Children’s Healthcare Quality [NICHQ], 2007). Children enrolled in Medicaid are six times as likely to be treated for obesity as children with private insurance (Marder, Chang, 2006). This may be an underestimate, given the difficulty children with Medicaid have in accessing the health system. Annual healthcare costs for children who are obese and enrolled in Medicaid are approximately \$6,700 compared with \$3,700 for obese children covered by private insurance; the national cost of treating children with obesity is estimated at roughly \$11 billion for children with private insurance compared with \$3 billion for those covered by Medicaid (Marder, Chang, 2006).

It has further been noted that children covered by Medicaid are less likely to visit the doctor and more likely to enter the hospital compared with children covered by private insurance (Marder, Chang, 2006). This may suggest that available outpatient resources are inadequate for these Medicaid patients. This lack of services may lead families to postpone seeking treatment, allowing conditions to deteriorate until urgent care is needed.

### **3.C. Relationship to Other Measures (if any)**

**Describe, if known, how this measure complements or improves on an existing measure in this topic area for the child or adult population, or if it is intended to fill a specific gap in an existing measure category or topic. For example, the proposed measure may enhance an existing measure in the initial core set, it may lower the age range for an existing adult-focused measure, or it may fill a gap in measurement (e.g., for asthma care quality, inpatient care measures).**

Many quality measures regarding pediatric BMI measurement and counseling exist. These measures assess, for populations of varying ages, regular measurement of BMI and documentation of BMI percentile; number of well-child visits with documented BMI; identification of weight classification status; and education about weight management strategies, including counseling regarding nutrition and physical activity. This measure, Communication of Weight Classification for Children Who Are Overweight or Obese, differs from existing measures in that it explicitly seeks to assess whether a healthcare provider has communicated the weight status of a child to the parent or guardian.

## Section 4. Measure Categories

CHIPRA legislation requires that measures in the initial and improved core set, taken together, cover all settings, services, and topics of health care relevant to children. Moreover, the legislation requires the core set to address the needs of children across all ages, including services to promote healthy birth. Regardless of the eventual use of the measure, we are interested in knowing all settings, services, measure topics, and populations that this measure addresses. These categories are not exclusive of one another, so please indicate "Yes" to all that apply.

Does the measure address this category?

- a. Care Setting – ambulatory: Yes.
- b. Care Setting – inpatient: No.
- c. Care Setting – other – please specify: No.
- d. Service – preventive health, including services to promote healthy birth: Yes.
- e. Service – care for acute conditions: No.
- f. Service – care for children with special health care needs/chronic conditions: Yes.
- g. Service – other (please specify): No.
- h. Measure Topic – duration of enrollment: No.
- i. Measure Topic – clinical quality: Yes.
- j. Measure Topic – patient safety: No.
- k. Measure Topic – family experience with care: No.
- l. Measure Topic – care in the most integrated setting: No.
- m. Measure Topic other (please specify): No.
- n. Population – pregnant women: No.
- o. Population – neonates (28 days after birth) (specify age range): No.
- p. Population – infants (29 days to 1 year) (specify age range): No.
- q. Population – pre-school age children (1 year through 5 years) (specify age range):  
Yes; ages 2 through 5 years.
- r. Population – school-aged children (6 years through 10 years) (specify age range):  
Yes; all ages in this range.
- s. Population – adolescents (11 years through 20 years) (specify age range): Yes; ages  
11 through 17 years (i.e., younger than 18 years of age).
- t. Population – other (specify age range): No.
- u. Other category (please specify): Not applicable.

## Section 5. Evidence or Other Justification for the Focus of the Measure

The evidence base for the focus of the measures will be made explicit and transparent as part of the public release of CHIPRA deliberations; thus, it is critical for submitters to specify the scientific evidence or other basis for the focus of the measure in the following sections.

## **5.A. Research Evidence**

**Research evidence should include a brief description of the evidence base for valid relationship(s) among the structure, process, and/or outcome of health care that is the focus of the measure. For example, evidence exists for the relationship between immunizing a child or adolescent (process of care) and improved outcomes for the child and the public. If sufficient evidence existed for the use of immunization registries in practice or at the State level and the provision of immunizations to children and adolescents, such evidence would support the focus of a measure on immunization registries (a structural measure).**

**Describe the nature of the evidence, including study design, and provide relevant citations for statements made. Evidence may include rigorous systematic reviews of research literature and high-quality research studies.**

This measure focuses on a process (communication of weight status to patients and/or families during an outpatient visit) that, if followed, results in a desirable clinical outcome (families gain an accurate understanding about their child's excess weight, as well as information to change eating habits and physical exercise behaviors to improve health). The measure highlights where providers or health systems are falling short in communicating weight status to patients and/or families.

National guidelines and expert consensus statements recommend that providers communicate weight status to patients and/or families. In 2007, the American Academy of Pediatrics (AAP), American Medical Association (AMA), and the Centers for Disease Control and Prevention (CDC) collaborated to form an expert committee to update recommendations on the prevention, assessment, and treatment of child and adolescent overweight and obesity. The committee recommended a minimum yearly assessment of weight status for all children, in which weight and height are plotted on standard sex- and age-appropriate growth charts to determine a BMI percentile and weight classification (Barlow, 2007). Once a child's BMI is measured, clinicians must exercise judgment, first in assessing the child's health and second in choosing language to inform the child and family (Barlow, 2007). Table 2 (see Supporting Documents) summarizes several key sources of evidence for this measure, using the U.S. Preventive Services Task Force (USPSTF) rankings (criteria denoted as a note to Table 2).

## **5.B. Clinical or Other Rationale Supporting the Focus of the Measure (optional)**

**Provide documentation of the clinical or other rationale for the focus of this measure, including citations as appropriate and available.**

Not applicable.

## **Section 6. Scientific Soundness of the Measure**

**Explain the methods used to determine the scientific soundness of the measure itself. Include results of all tests of validity and reliability, including description(s) of the study**

**sample(s) and methods used to arrive at the results. Note how characteristics of other data systems, data sources, or eligible populations may affect reliability and validity.**

## **6.A. Reliability**

**Reliability of the measure is the extent to which the measure results are reproducible when conditions remain the same. The method for establishing the reliability of a measure will depend on the type of measure, data source, and other factors.**

**Explain your rationale for selecting the methods you have chosen, show how you used the methods chosen, and provide information on the results (e.g., the Kappa statistic). Provide appropriate citations to justify methods.**

This measure is based on medical records data; reliability testing is described here.

### **Data and Methods**

Our testing data were obtained through an audit of medical records maintained by HealthCore, Inc. HealthCore is an independent subsidiary of Anthem, Inc., the largest health benefits company/insurer in the United States. HealthCore owns and operates the HealthCore Integrated Research Database (HIRD), a longitudinal database of medical and pharmacy claims and enrollment information for members from 14 geographically diverse BCBS health plans in the Northeast, South, West and Central regions of the United States, with members living in all 50 States. In total, the HIRD included data for approximately 59 million individuals enrolled between January 2006 and June 2014.

More than 12 million members were enrolled at some point during the 2013 measurement year for this study, among which 2.3 million were aged 2-18 years old. There were 637,100 children aged 2-18 years with a routine outpatient encounter in 2013 who were currently enrolled and were fully insured. This group was narrowed to a subset that had a provider with a specialty of pediatric medicine or general practice/family practice (451,003). One child per family was then randomly selected, resulting in 293,741 eligible children from all 50 States, as well as the District of Columbia and territories such as Puerto Rico and the Virgin Islands.

A simple random sample (SRS) was used to select 27,000 candidates for a parent survey of which 26,569 (98 percent) had valid contact information. From this group, a total of 1,580 parent surveys were completed; of these, 402 parents reported that their eligible child had a BMI  $\geq$ 85th percentile.

Additionally, an independent SRS of 750 candidates was selected to provide additional cases for medical record abstraction to ensure the study goal for abstracted charts would be achieved; 722 children from this group had valid contact information. Combining these two groups, medical records were requested for review for 1,124 (402+722) children. In total, 600 medical records were reviewed and abstracted.

Once subjects were identified, patient medical records were requested from provider offices and healthcare facilities; these records were sent to a centralized location for data abstraction. Trained nurse or pharmacist medical record abstractors collected and entered information from

paper copies of the medical records into a password-protected database. To help ensure consistency of data collection, the medical record abstractors were trained on the study's design and presented with a standardized data collection form designed to minimize the need to make subjective judgments during the abstraction process. In addition, data entered onto a scanner form and subsequently scanned was reviewed through a series of quality checks.

Reliability of medical record data was determined through re-abstraction of patient record data to calculate the inter-rater reliability (IRR). Broadly, IRR is the extent to which the abstracted information is collected in a consistent manner. Low IRR may be a sign of poorly executed abstraction procedures, such as ambiguous wording in the data collection tool, inadequate abstractor training, or abstractor fatigue. For this measure, the medical record data collected by two abstractors were individually compared with the data obtained by a senior abstractor to gauge the IRR for each abstractor. Any differences were remedied by review of the chart. IRR was determined by calculating both percent agreement and Cohen's Kappa statistic.

## **Results**

Data were abstracted from 600 medical records; 216 children (36.0 percent) met denominator criteria as being between 2 and 17 years of age and having a calculated BMI  $\geq$ 85th percentile, based on height and weight from the medical record. Of these, 20 records (9.3 percent) from the two abstractors were reviewed for IRR. Agreement was assessed for three measure variables: documentation of communication of weight status, documentation of height, and documentation of weight (necessary to calculate BMI).

Table 3 (see Supporting Documents) shows the percent agreement and Kappa statistic for each variable. Abstractor agreement for documentation of communication regarding weight status was 90 percent, with a Kappa statistic of 0.899. Agreement for documentation of height and documentation of weight were both 100 percent, with Kappa statistics of 1. These results indicate a very high level of IRR was achieved for all measure variables.

## **6.B. Validity**

**Validity of the measure is the extent to which the measure meaningfully represents the concept being evaluated. The method for establishing the validity of a measure will depend on the type of measure, data source, and other factors.**

**Explain your rationale for selecting the methods you have chosen, show how you used the methods chosen, and provide information on the results (e.g., R2 for concurrent validity).**

### **Face Validity**

Face validity is the degree to which the measure construct characterizes the concept being assessed. The face validity of this measure was established by a national panel of experts and advocates for families of children with high BMI convened by Q-METRIC. The Q-METRIC expert panel included nationally recognized experts in childhood obesity, representing pediatrics, nephrology, nutrition and dietetics, endocrinology, gastroenterology, health behavior/education, and family advocacy. In addition, measure validity was considered by experts in State Medicaid program operations, health plan quality measurement, health informatics, and healthcare quality



measurement. In total, the Q-METRIC High BMI Follow-Up panel included 17 experts, providing a comprehensive perspective on childhood obesity and the measurement of quality metrics for States and health plans.

The Q-METRIC expert panel concluded that this measure has a high degree of face validity through a detailed review of concepts and metrics considered to be essential to effective management and treatment of childhood obesity. Concepts and draft measures were rated by this group for their relative importance. This measure was very highly rated, receiving an average score of 7.9 (with 9 as the highest possible score).

### **Abstracted Medical Record Data**

This measure was tested using medical records data. This source is considered the gold standard for clinical information. Our findings indicate that these data have a high degree of face validity and reliability. In total, 600 charts were reviewed.

The eligible population for the denominator is the number of children ages 2 through 17 years with a BMI  $\geq 85^{\text{th}}$  percentile who had an outpatient care visit during the measurement year (January 1-December 31). This measure was tested using two methods for determining the denominator:

1. Calculated BMI  $\geq 85^{\text{th}}$  percentile based on BMI calculated from height and weight recorded in the medical record.
2. Recorded BMI  $\geq 85^{\text{th}}$  percentile based on a BMI percentile recorded in the medical record.

### **Calculated BMI**

A total of 216 children (36.0 percent) met denominator criteria as being between 2 and 17 years old and having a calculated BMI  $\geq 85^{\text{th}}$  percentile, based on height and weight from the medical record. Among these children, 4.6 percent (n=10) had documentation of communication of weight classification at an outpatient care visit during the measurement year (Table 4; see Supporting Documents).

### **Recorded BMI**

Overall, 91 children (15.2 percent) met denominator criteria for being between 2 and 17 years old and having a recorded BMI (based on a BMI percentile recorded by the provider)  $\geq 85^{\text{th}}$  percentile. Among these children, seven children (7.7 percent) had documentation of communication of weight classification at an outpatient care visit during the measurement year (Table 4; see Supporting Documents).

## **Section 7. Identification of Disparities**

**CHIPRA requires that quality measures be able to identify disparities by race, ethnicity, socioeconomic status, and special health care needs. Thus, we strongly encourage nominators to have tested measures in diverse populations. Such testing provides evidence for assessing measure's performance for disparities identification. In the sections below,**

**describe the results of efforts to demonstrate the capacity of this measure to produce results that can be stratified by the characteristics noted and retain the scientific soundness (reliability and validity) within and across the relevant subgroups.**

## **7.A. Race/Ethnicity**

Recent analyses by Ogden and colleagues (2014) of data from the 2011-2012 National Health and Nutrition Examination Survey (NHANES) covered many demographic aspects of childhood obesity, including race. Among NHANES participants aged 2 to 19 years, the prevalence of obesity (BMI $\geq$ 95th percentile) was highest in Hispanics (22 percent) compared with non-Hispanic blacks (20 percent), non-Hispanic whites (14 percent), and non-Hispanic Asians (9 percent) (Ogden, et al., 2014). This order was consistent among racial and ethnic groups when looked at by sex: Hispanic boys and girls had the highest incidence of obesity (24 percent and 21 percent, respectively) compared with non-Hispanic black boys and girls (20 percent and 21 percent), white boys and girls (13 percent and 16 percent), and Asian boys and girls (12 percent and 6 percent). The order also held when considering the broader category of those who were overweight or obese (i.e., having a BMI  $\geq$ 85th percentile): Hispanic boys and girls had the highest incidence of obesity (41 percent and 37 percent, respectively), compared with non-Hispanic black boys and girls (34 percent and 36 percent), white boys and girls (28 percent and 29 percent), and Asian boys and girls (25 percent and 14 percent). In both weight classifications, Hispanic boys had the highest rate of obesity and Asian girls the lowest; for both black and white children, girls tended to have slightly higher rates of excess weight than boys (Ogden, et al., 2014).

It is interesting to note that two studies reported better communication regarding the topic of excess weight among children who often receive substandard care. Non-Hispanic black girls were more likely to be told they were overweight compared with non-Hispanic white girls (47 percent vs. 31 percent) (Ogden, Tabak, 2005); and, notification of overweight status by a doctor or health professional was more likely to occur among Mexican American and other Hispanic children. There was a trend toward increased notification about excess weight to the parents of non-Hispanic black and publicly insured children (Perrin, et al., 2012). This is the opposite of most health-related disparities (Perrin, et al., 2012).

### **Census Characteristics**

Race and ethnicity were not available from the medical records reviewed for this study. However, the overall race and ethnicity characteristics can be summarized using demographic characteristics based upon ZIP codes of sampled children. This race/ethnicity information was obtained from the 2010 United States Census (U.S. Census Bureau, 2010), which enables characterization of the areas in which sampled children live.

These summary statistics are reported in Tables 5 and 6 (see Supporting Documents) for the following sampled individuals with valid ZIP codes:

1. Candidates for the parent survey with non-missing contact information (n=26,569; n=25,961 with valid ZIP codes).
2. An SRS for medical chart abstraction (n=722; n=711 with valid ZIP codes).

3. A subset of children with reviewed and abstracted medical records (a combination of medical records from the SRS and the parent survey, n=600; n=590 with valid ZIP codes).

Overall, the proportion of residents in specific racial groups was similar in all three groups of sampled children. On average, sampled children reside in ZIP codes reporting primarily white race and approximately 10-11 percent of residents within ZIP codes reporting Hispanic ethnicity.

## **7.B. Special Health Care Needs**

The medical records data abstracted for this study did not include indicators of special healthcare needs.

## **7.C. Socioeconomic Status**

Findings have varied regarding the relationship between socioeconomic status and excess weight. In 2003, Gordon-Larsen and colleagues reported that in adolescents (ages 12 to 20 years), overweight prevalence decreased among white girls as their socioeconomic status increased, while the reverse was true for African American girls. Higher socioeconomic status was associated with elevated and/or increasing BMI in African American adolescent girls. The authors suggest that efforts to reduce disparities regarding excess weight between ethnic groups must look beyond income and education to consider environmental, contextual, biological, and sociocultural influences (Gordon-Larsen, Adair, Popkin, 2003). More recent findings by Miech and colleagues produced different results when dividing adolescents into two age groups (12- to 14-year olds and 15- to 17-year olds). Trends of increasing overweight showed a greater effect among families living below the poverty line compared with those above it for older, but not younger adolescents. Additional analyses suggested that physical inactivity and eating habits such as skipping breakfast and consuming sugary drinks contributed to disparities. The authors reason that there is a unique association in later adolescence between poverty and overweight because food choices and activity levels at this age differ considerably from those of early childhood and adulthood. Older adolescents have opportunities and discretionary income to make their own choices regarding food and activities (Miech, Kumanyika, Stettler, et al., 2006).

### **Census Characteristics**

Although socioeconomic status was not available from the medical records reviewed for this study, the overall median household income can be summarized based upon the overall characteristics of the ZIP codes of sampled children. This information was obtained from the 2011 American Community Survey (ACS) (U.S. Census Bureau, 2013), which enables characterization of the areas in which sampled children live.

The summary statistics for median household income are reported in Table 7 (see Supporting Documents) for the following sampled individuals with valid ZIP codes:

1. Candidates for the parent survey with non-missing contact information (n=26,569; n=25,961 with valid ZIP codes).
2. An SRS for medical chart abstraction (n=722; n=711 with valid ZIP codes).

3. A subset of children with reviewed and abstracted medical records (a combination of medical records from the SRS and the parent survey, n=600; n=590 with valid ZIP codes).

Overall, median household income at the ZIP code level was similar among the candidates for the parent survey and the SRS for medical chart abstraction (\$71,418); the median household income for the subset with reviewed and abstracted medical charts was slightly lower at \$66,679.

## **7.D. Rurality/Urbanicity**

### **Census Characteristics**

Urbanicity was not available from the medical records reviewed for this study. However, urbanicity can be summarized based upon the overall characteristics of the ZIP codes of sampled children. This information was obtained from the 2010 United States Census (U.S. Census Bureau, 2010), which enables characterization of the areas in which sampled children live.

The summary statistics for urbanicity are reported in Table 8 (see Supporting Documents) for the following sampled individuals with valid ZIP codes:

1. Candidates for the parent survey with non-missing contact information (n=26,569; n=25,961 with valid ZIP codes).
2. An SRS for medical chart abstraction (n=722; n=711 with valid ZIP codes).
3. A subset of children with reviewed and abstracted medical records (a combination of medical records from the SRS and the parent survey, n=600; n=590 with valid ZIP codes).

Overall, the ZIP codes of the candidates for the parent survey and the ZIP codes for the SRS for medical chart abstraction were largely categorized as being urban (80.4 percent); the subset of candidates with reviewed and abstracted medical charts resided in ZIP codes categorized as urban to a lesser degree (76.7 percent).

## **7.E. Limited English Proficiency (LEP) Populations**

The medical records data abstracted for this study did not include indicators of LEP.

## **Section 8. Feasibility**

**Feasibility is the extent to which the data required for the measure are readily available, retrievable without undue burden, and can be implemented for performance measurement. Using the following sections, explain the methods used to determine the feasibility of implementing the measure.**

## 8.A. Data Availability

### 1. What is the availability of data in existing data systems? How readily are the data available?

As noted within the Reliability section of this report, our testing data consisted of an audit of medical records acquired by HealthCore, Inc., which maintains the HealthCore Integrated Research Database (HIRD). This longitudinal database contains medical and pharmacy claims and enrollment information for members from 14 geographically diverse BCBS health plans, with members living in all 50 States. In total, the HIRD includes approximately 59 million individuals enrolled between January 2006 and June 2014.

More than 12 million members were enrolled at some point during the 2013 measurement year that was used for this study, among which 2.3 million were aged 2-18 years. The sample began with 1,048,559 children aged 2-18 years with a routine outpatient encounter in 2013. This group was subsequently narrowed as described in the Reliability section of this report.

In total, 600 charts were reviewed. The eligible population for the denominator is the number of children, ages 2 through 17 years, with a BMI  $\geq$ 85<sup>th</sup> percentile, who had an outpatient care visit during the measurement year (January 1-December 31). This measure was tested using two methods for determining the denominator:

1. Calculated BMI  $\geq$  85<sup>th</sup> percentile; based on BMI calculated from height and weight recorded in the medical record.
2. Recorded BMI  $\geq$  percentile; based on a BMI percentile recorded in the medical record.

#### Calculated BMI

A total of 216 children (36.0 percent) met denominator criteria as being between 2 through 17 years of age and having a calculated BMI  $\geq$ 85<sup>th</sup> percentile, based on height and weight from the medical record. Among these children, 4.6 percent (n=10) had documentation of communication of weight classification at an outpatient care visit during the measurement year (Table 4; see Supporting Documents).

#### Recorded BMI

Overall, 91 children (15.2 percent) met denominator criteria for being age 2 through 17 years and having a recorded BMI (based on a BMI percentile recorded by the provider)  $\geq$  85<sup>th</sup> percentile. Among these children, seven children (7.7 percent) had documentation of communication of weight classification at an outpatient care visit during the measurement year (Table 4; see Supporting Documents).

Data abstraction was completed by experienced medical record abstractors who were trained on the study's design and presented with a standardized data collection form. In addition to the specific data values required for this measure, key patient characteristics—such as date of birth and sex—were also obtained.

## **Abstraction Times**

In addition to calculating IRR, the study team assessed how burdensome it was to locate and document the information used to test this measure by having abstractors note the time it took to complete each record. On average, the abstractors spent 1 minute per record abstracting the data for this measure.

**2. If data are not available in existing data systems or would be better collected from future data systems, what is the potential for modifying current data systems or creating new data systems to enhance the feasibility of the measure and facilitate implementation?**

Not applicable.

## **8.B. Lessons from Use of the Measure**

**1. Describe the extent to which the measure has been used or is in use, including the types of settings in which it has been used, and purposes for which it has been used.**

Not applicable.

**2. If the measure has been used or is in use, what methods, if any, have already been used to collect data for this measure?**

Not applicable.

**3. What lessons are available from the current or prior use of the measure?**

Not applicable.

## **Section 9. Levels of Aggregation**

**CHIPRA states that data used in quality measures must be collected and reported in a standard format that permits comparison (at minimum) at State, health plan, and provider levels. Use the following table to provide information about this measure's use for reporting at the levels of aggregation in the table.**

**For the purpose of this section, please refer to the definitions for provider, practice site, medical group, and network in the Glossary of Terms.**

**If there is no information about whether the measure could be meaningfully reported at a specific level of aggregation, please write "Not available" in the text field before progressing to the next section.**

***Level of aggregation (Unit) for reporting on the quality of care for children covered by Medicaid/ CHIP†:***

*State level\* Can compare States*

**Intended use: Is measure intended to support meaningful comparisons at this level?  
(Yes/No)**

No.

**Data Sources: Are data sources available to support reporting at this level?**

Not applicable.

**Sample Size: What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?**

Not applicable.

**In Use: Have measure results been reported at this level previously?**

Not applicable.

**Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?**

Not applicable.

**Unintended consequences: What are the potential unintended consequences of reporting at this level of aggregation?**

Not applicable.

*Other geographic level: Can compare other geographic regions (e.g., MSA, HRR)*

**Intended use: Is measure intended to support meaningful comparisons at this level?  
(Yes/No)**

No.

**Data Sources: Are data sources available to support reporting at this level?**

Not applicable.

**Sample Size: What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?**

Not applicable.

**In Use: Have measure results been reported at this level previously?**

Not applicable.

**Reliability & Validity: Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?**

Not applicable.

***Unintended consequences:*** What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

***Medicaid or CHIP Payment model:*** Can compare payment models (e.g., managed care, primary care case management, FFS, and other models)

***Intended use:*** Is measure intended to support meaningful comparisons at this level? (Yes/No)

No.

***Data Sources:*** Are data sources available to support reporting at this level?

Not applicable.

***Sample Size:*** What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?

Not applicable.

***In Use:*** Have measure results been reported at this level previously?

Not applicable.

***Reliability & Validity:*** Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

Not applicable.

***Unintended consequences:*** What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

***Health plan\*:*** Can compare quality of care among health plans.

***Intended use:*** Is measure intended to support meaningful comparisons at this level? (Yes/No)

Yes.

***Data Sources:*** Are data sources available to support reporting at this level?

This measure requires medical record abstraction; medical records are maintained by all health services providers.

***Sample Size:*** What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?

This record has not been tested at the health plan level; consequently, the minimum number of providers per plan has not been determined.

***In Use:*** Have measure results been reported at this level previously?

Not available.



**Reliability & Validity:** Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

Not available.

**Unintended consequences:** What are the potential unintended consequences of reporting at this level of aggregation?

Not available.

**Provider Level**

**Individual practitioner:** Can compare individual health care professionals

**Intended use:** Is measure intended to support meaningful comparisons at this level?  
(Yes/No)

Yes.

**Data Sources:** Are data sources available to support reporting at this level?

This measure requires medical record abstraction; medical records are maintained by all health services providers.

**Sample Size:** What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?

Availability of medical records meeting inclusion criteria will vary by practice, but a requirement is that providers furnish services to children. A minimum of 30 abstracted charts for children with a BMI  $\geq$ 85th percentile is recommended. Our results indicate that approximately 30 percent of children in the eligible age group met this criterion based on calculated BMI, which indicates that approximately 100 charts for children in the eligible age range will require abstraction. If sample size is to be determined based on recorded BMI percentile, our results indicate that approximately 200 charts for children in the eligible age range will require abstraction.

**In Use:** Have measure results been reported at this level previously?

Not available.

**Reliability & Validity:** Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

Not available.

**Unintended consequences:** What are the potential unintended consequences of reporting at this level of aggregation?

Not available.

**Provider Level**

**Hospital:** Can compare hospitals

**Intended use:** Is measure intended to support meaningful comparisons at this level?  
(Yes/No)

No.

**Data Sources:** Are data sources available to support reporting at this level?

Not applicable.

**Sample Size:** What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?

Not applicable.

**In Use:** Have measure results been reported at this level previously?

Not applicable.

**Reliability & Validity:** Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

Not applicable.

**Unintended consequences:** What are the potential unintended consequences of reporting at this level of aggregation?

Not applicable.

**Provider Level**

**Practice, group, or facility:\*\* Can compare: (i) practice sites; (ii) medical or other professional groups; or (iii) integrated or other delivery networks**

**Intended use:** Is measure intended to support meaningful comparisons at this level?

(Yes/No)

Yes.

**Data Sources:** Are data sources available to support reporting at this level?

This measure requires medical record abstraction; medical records are maintained by all health services providers.

**Sample Size:** What is the typical sample size available for each unit at this level? What proportion of units at this level of aggregation can achieve an acceptable minimum sample size?

This measure has not been tested at the practice group or facility level; consequently, the minimum number of providers per group has not been determined.

**In Use:** Have measure results been reported at this level previously?

Not available.

**Reliability & Validity:** Is there published evidence about the reliability and validity of the measure when reported at this level of aggregation?

Not available.

***Unintended consequences:* What are the potential unintended consequences of reporting at this level of aggregation?**

Not available.

## **Section 10. Understandability**

**CHIPRA states that the core set should allow purchasers, families, and health care providers to understand the quality of care for children. Please describe the usefulness of this measure toward achieving this goal. Describe efforts to assess the understandability of this measure (e.g., focus group testing with stakeholders).**

This measure provides families with a straightforward means to assess how well basic levels of comprehensive care are being provided for children in regard to assessing weight status by communicating with patients and parents about the weight classification of children who are overweight or obese. Low rates for the provision of care are easily understood to be unsatisfactory. The simplicity of the measure likewise makes it a straightforward guide for providers and purchasers to assess how well comprehensive care is provided to children in order to assess, prevent, and treat obesity.

This measure has not been assessed for comprehension. The primary information needed for this measure comes from medical record data and includes basic demographics, weight classification, diagnostic codes, procedure codes, and dates of services, all of which are widely available.

## **Section 11. Health Information Technology**

**Please respond to the following questions in terms of any health information technology (health IT) that has been or could be incorporated into the measure calculation.**

### **11.A. Health IT Enhancement**

**Please describe how health IT may enhance the use of this measure.**

This is a complex measure that will require data from a number of potential sources in the electronic health record (EHR), depending on the practice workflow. EHRs can alert providers to the need to capture height and weight at each visit, which are essential components of BMI percentile calculation. In addition, health information technology (IT) can be used to provide alerts to all practice staff at workflow-appropriate timings, once these measures are obtained. For example, communication about weight classification might be an alert the provider receives before signing a note. Similarly, a prompt to record a blood pressure might be provided to a nurse on a dashboard that he or she sees before discharging the patient in order to foster the recording of more complete information at each patient visit.

Electronic health tools offer benefits for addressing overweight and obesity: more complete and accurate data with fewer errors, cost-effectiveness, use of online assessment tools, ease of sharing data, more security, elimination of paper document storage; and shorter time for analysis.

Disadvantages include providers transitioning to new data collection workflows, cost, logistics, and intellectual property concerns (Daniels, et al., 2009).

## **11.B. Health IT Testing**

**Has the measure been tested as part of an electronic health record (EHR) or other health IT system?**

No.

**If so, in what health IT system was it tested and what were the results of testing?**

Not applicable.

## **11.C. Health IT Workflow**

**Please describe how the information needed to calculate the measure may be captured as part of routine clinical or administrative workflow.**

This measure will require the aggregation of data collected and stored in various locations in the EHR, by various stakeholders, and likely using variable ways to represent work. For example, documentation of weight classification requires the child's age in months (under age 36 months) or years, so that one of the terms listed (e.g., normal weight) can be searched for—including all abbreviations—in nursing notes, physician notes, and technician notes. Other ways to classify weight, such as BMI percentile, will likely be found in the vital signs. Over the age of 16 years, the data might be found in the vital signs or in the documentation sections of the record.

## **11.D. Health IT Standards**

**Are the data elements in this measure supported explicitly by the Office of the National Coordinator for Health IT Standards and Certification (ONC) criteria (see [healthit.hhs.gov/portal/server.pt/community/healthit\\_hhs\\_gov\\_\\_standards\\_ifr/1195](http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__standards_ifr/1195))?**

Yes.

**If yes, please describe.**

The ONC's Health IT Standards explicitly address the recording of vital signs such as height, weight, and BMI into EHRs, which are directly relevant to this measure. The ONC standards include the following specific requirements in the Certification criteria (ONC, 2010) pertaining to Stage 2 Meaningful Use requirements:

- Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse.
- Automatically calculate and display BMI based on a plot and display patient's height and weight.
- Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.

## **11.E. Health IT Calculation**

**Please assess the likelihood that missing or ambiguous information will lead to calculation errors.**

Missing or ambiguous information in the following areas could lead to missing cases or calculation errors:

1. Child's date of birth.
2. Date and times of treatment.
3. Codes selected to identify obesity or abnormal weight gain.
4. BMI percentile or score.
5. Weight classification based on BMI percentile or score.
6. Choice of CPT, HCPCS, or ICD-9-CM diagnosis codes to identify outpatient care visits.

## **11.F. Health IT Other Functions**

**If the measure is implemented in an EHR or other health IT system, how might implementation of other health IT functions (e.g., computerized decision support systems in an EHR) enhance performance characteristics on the measure?**

Performance on this measure could benefit from a number of health IT integration steps:

- Documentation templates filled out by providers (or potentially by scribes, in communication with providers during the visit) could improve provider behavior with respect to these issues during the visit.
- Documentation templates created in specialty clinics could help with missed opportunities to provide this counseling in emergency departments, other clinic visits, home visits, or through patient-initiated contact with the health system via a patient portal or personal health application.
- Active decision support before, during, or after the visit could prompt providers or patients about these issues.
- EHRs could generate triggers to providers to document their assessments more carefully.

## **Section 12. Limitations of the Measure**

**Describe any limitations of the measure related to the attributes included in this CPCF (i.e., availability of measure specifications, importance of the measure, evidence for the focus of the measure, scientific soundness of the measure, identification of disparities, feasibility, levels of aggregation, understandability, health information technology).**

This measure assesses the percentage of children, ages 2 through 17 years, with a BMI  $\geq$ 85th percentile, who had documentation of communication of weight classification at an outpatient

care visit during the measurement year. If healthcare providers discuss weight with families in a timely, informative, and supportive manner, they can foster the confidence and skills necessary for parents and children to address dietary and physical activity behaviors. A higher percentage of documentation of BMI percentile indicates better performance.

This measure was developed with the use of medical record data. The testing results reported here required the development of an abstraction tool and use of qualified medical record abstractors.

Information needed for this measure includes demographics, date of birth, diagnosis codes, height, weight, and free text documentation in the note from the clinician. Our findings indicate that these data are generally available.

We did, however, observe some limitations. Height and/or weight were sometimes missing from the chart, and there could be substantial variation in how providers document/describe their assessment. In future implementation, the use of data from electronic medical records may ease the burden of data collection.

## **Section 13. Summary Statement**

**Provide a summary rationale for why the measure should be selected for use, taking into account a balance among desirable attributes and limitations of the measure. Highlight specific advantages that this measure has over alternative measures on the same topic that were considered by the measure developer or specific advantages that this measure has over existing measures. If there is any information about this measure that is important for the review process but has not been addressed above, include it here.**

This measure, Communication of Weight Classification for Children Who Are Overweight or Obese, assesses the percentage of children, ages 2 through 17 years, with a BMI  $\geq$ 85th percentile, who had documentation of communication of weight classification at an outpatient care visit during the measurement year. Making families aware of excess weight issues for their children is an essential step toward creating the healthy changes that support appropriate weight levels. A higher percentage of communication of weight classification indicates better performance. This measure was tested using medical record data. While similar measures exist, this measure differs in that it explicitly seeks to assess whether a healthcare provider has communicated the weight classification of a child to the parent or guardian.

Nearly a third of young children and adolescents in the United States are either overweight or obese. This situation is of pressing concern, given the association between obesity in children and a broad spectrum of serious health issues. Health risks and body fat levels are proportionate. Weight classifications provide a useful framework to identify concerns associated with higher levels of excess weight. If healthcare providers discuss weight with families in a timely, informative, and supportive manner, they can foster the confidence and skills necessary for parents and children to address dietary and physical activity behaviors. Improving the frequency and quality of these conversations is an essential first step toward helping children reach and maintain a healthy weight. However, research shows that providers often do not discuss weight

issues with parents of overweight or obese patients or do so inadequately. Issues that make these discussions difficult include lack of familiarity with guidelines, too little support and time for providers in the clinic, concerns about stigmatization, and parental misperceptions about normal versus overweight in their own children.

Data were abstracted from the medical records of 600 children. For calculated BMI, 216 children (36.0 percent) met denominator criteria as being ages 2 through 17 years and having a calculated BMI  $\geq$ 85th percentile, based on height and weight from the medical record. Among these children, 4.6 percent (n=10) had documentation of communication of weight classification at an outpatient care visit during the measurement year. For recorded BMI, 91 children (15.2 percent) met the same denominator criteria for age and having a recorded BMI (based on a BMI percentile recorded by the provider)  $\geq$ 85th percentile. Among these children, 7 children (7.7 percent) had documentation of communication of weight classification at an outpatient care visit during the measurement year. Limitations for this measure include missing chart values for height and/or weight, as well as substantial variation in how providers document/describe their assessment.

This measure provides a straightforward means to assess how well basic levels of comprehensive care are being provided for children in regard to assessing weight status by informing parents of a child's weight classification. The primary information needed for this measure includes basic demographics, dates of services, BMI percentile, communication notes, diagnostic codes, and procedure codes, all of which are widely available. Continuing advances in the development and implementation of health IT may establish the feasibility of regularly implementing this measure with data supplied by electronic medical records.

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## **Section 14: Identifying Information for the Measure Submitter**

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**The CHIPRA Pediatric Quality Measures Program (PQMP) Candidate Measure Submission Form (CPCF) was approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act.**

**The OMB Control Number is 0935-0205 and the Expiration Date is December 31, 2015.**

## **Public Disclosure Requirements**

**Each submission must include a written statement agreeing that, should U.S. Department of Health and Human Services accept the measure for the 2014 and/or 2015 Improved Core Measure Sets, full measure specifications for the accepted measure will be subject to public disclosure (e.g., on the Agency for Healthcare Research and Quality [AHRQ] and/or Centers for Medicare & Medicaid Services [CMS] websites), except that potential measure users will not be permitted to use the measure for commercial use. In addition, AHRQ expects that measures and full measure specifications will be made reasonably available to all interested parties. "Full measure specifications" is defined as all information that any potential measure implementer will need to use and analyze the measure, including use and analysis within an electronic health record or other health information technology. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure. This statement must be signed by an individual authorized to act for any holder of copyright on each submitted measure or instrument. The authority of the signatory to provide such authorization should be described in the letter.**

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