General

Title

Sickle cell disease (SCD): percentage of children in a state between the ages of 3 months and 5 years diagnosed with SCD who received appropriate antibiotic prophylaxis for at least 350 days during the measurement year.

Source(s)


Measure Domain

Primary Measure Domain

Population Health Quality Measures: Population Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of children in a state between the ages of 3 months and 5 years diagnosed with sickle cell disease (SCD) who received appropriate antibiotic prophylaxis for at least 350 days during the measurement year.

Rationale

Spleen damage is a common and crucial characteristic of sickle cell disease (SCD): a damaged spleen cannot effectively clear bacteria from the blood, leaving SCD patients, particularly young children, highly susceptible to infection. Children with SCD experience rates of infection caused by the bacterium *Streptococcus pneumoniae* 30 to 100 times more frequently than children without SCD. Pneumococcal vaccines are of limited effectiveness in this age group because of lowered antibody response. However,
twice-daily doses of an antibiotic sharply reduce the incidence of *S. pneumoniae* disease in children with SCD.

Studies have shown that children with SCD who are enrolled in Medicaid frequently are not dispensed antibiotics soon enough or in sufficient quantities to cover ongoing twice-daily use. Sometimes these children receive no antibiotics at all, even though this simple preventive medication greatly reduces their risk of contracting debilitating and often deadly infections. Clinical guidelines and the results of randomized controlled trials indicate that providers should prescribe appropriate antibiotic prophylaxis to children with SCD who are under 5 years of age. There are no existing quality measures for antibiotic prophylaxis in children with SCD.

Prompt initiation and consistent use of antibiotics in young children with SCD increases survival rates through the prevention of overwhelming bacterial infections (National Heart, Lung and Blood Institute [NHLBI], 2002). Because sickle cells obstruct blood flow to the spleen, splenic function is compromised, leading to susceptibility to bacterial infections (NHLBI, 2002). Meningitis, pneumonia, and sepsis are major causes of death in children with SCD, and pneumococcal sepsis is known to progress from the onset of fever to death in fewer than 12 hours (Gaston et al., 1986). Given that the highest rate of infection occurs in children with SCD under the age of 3 years (Hirst & Owusu-Ofori, 2010), NHLBI guidelines recommend that infants identified through newborn screening (NBS) as having SCD should be started on daily prophylactic penicillin as early as possible and remain on preventive antibiotics until age 5 years (2002).

**Evidence for Rationale**


**Primary Health Components**

Sickle cell disease (SCD); antibiotic prophylaxis; children

**Denominator Description**

The eligible population consists of children in a state aged 90 days or older on January 1 of the measurement year but younger than 5 years on December 31 of the measurement year who are continuously enrolled in Medicaid and received an appropriate sickle cell disease (SCD)-related International Classification of Diseases, Ninth Revision (ICD-9) code on three or more separate health care encounters during the measurement year (see the related "Denominator Inclusions/Exclusions" field).
Numerator Description

The number of eligible children in a state who received appropriate antibiotic prophylaxis for at least 350 days, as determined by administrative record review (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

A systematic review of the clinical research literature (e.g., Cochrane Review)

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

Sickle Cell Disease Prevalence and Incidence

Sickle cell disease (SCD) is one of the most common genetic disorders in the United States (Kavanagh et al., 2011). The National Heart, Lung and Blood Institute (NHLBI) (2002) estimates that 2,000 infants are born with SCD in the United States (U.S.) each year. SCD affects 70,000 to 100,000 children and adults in the United States, predominantly those of African and Hispanic descent (Hassell, 2010).

Sickle Cell Disease Pathology and Severity

Vaso-occlusion (the sudden blockage of a blood vessel caused by the sickle shape of abnormal blood cells) is responsible for most complications of SCD, including pain episodes, sepsis, stroke, acute chest syndrome, priapism, leg ulcers, osteonecrosis and renal insufficiency (Steinberg, 1999). In addition, SCD can have hemolytic and infectious complications that result in morbidity and mortality in children with SCD (Kavanagh et al., 2011).

Sickle Cell Disease Burden in Daily Life

The effect of SCD on children and families is significant: severe pain episodes and hospitalizations restrict daily activities and reflect negatively on school attendance and performance, sleep, and social activities (Lemanek, Ranalli, & Lukens, 2009; Alvim et al., 2005). Although medical management of SCD continues to improve over time, 196 U.S. children died from SCD-related causes between 1999 and 2002 (Yanni et al., 2009).

Sickle Cell Disease Cost

In a study of health care utilization among low income children with SCD between 2004 and 2007, 27% of these children required inpatient hospitalization and 39% used emergency care during a year. Of these children, 63% averaged one well-child visit per year and 10% had at least one outpatient visit with a specialist (Raphael et al., 2009). Patients with SCD use many parts of the health care system, incurring significant costs. In 2009, mean hospital charges for children with SCD and a hospital stay were $23,000 for children with private insurance and $18,200 for children enrolled in Medicaid (HCUPnet, Healthcare Cost and Utilization Project, 2012). Kauf et al. (2009) estimate the lifetime cost of health care per patient with SCD to be approximately $460,000.

Performance Gap – Prophylactic Antibiotics

In one study, children with SCD and enrolled in Medicaid were dispensed, on average, enough prophylactic medication to cover only 40% of the study year (Sox et al., 2003). Approximately 22% of children
received medication to cover more than 270 days, but about 43% received 90 days of medication or less, and 10% of children received no antibiotics at all. These findings show a clear performance gap in the daily provision of prophylactic antibiotics to children with SCD.

In a study of 248 pediatricians regarding their knowledge and adherence to sickle cell guidelines, 97% of pediatricians answered correctly questions about the necessity of antibiotics for children with SCD, yet only 66% of pediatricians reported prescribing prophylactic antibiotics for 100% of their patients with SCD (Wurst & Sleath, 2004). Although pediatricians understand the necessity of prophylactic antibiotics for children with SCD, they do not always prescribe them as recommended.

Evidence for Additional Information Supporting Need for the Measure


Extent of Measure Testing

Reliability

*Data/Sample*. Our sample consisted of six states with a moderate-to-high prevalence of sickle cell disease (SCD): Florida, Illinois, Louisiana, Michigan, South Carolina, and Texas. Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium (Q-METRIC) tested this measure using a sample drawn from 5 consecutive years of Medicaid Analytic eXtract (MAX) administrative claims data provided by the Centers for Medicare & Medicaid Services (CMS). The measure was implemented using MAX data for each state to evaluate consistency of results for the most current 5-year period for which MAX data were available. This measure was tested as specified, which requires the assessment among the entire population of children with SCD between the ages of 3 months and 5 years within the measurement year. This measure does not involve sampling within states; all SCD cases are included in the measure specification.

For two states (Michigan and Illinois) additional samples of administrative claims were obtained directly from the respective state Medicaid programs to evaluate the reliability of using MAX administrative data for this measure. In addition, we conducted a medical record review in Michigan to evaluate the coding reliability and accuracy of Medicaid administrative claims for antibiotic prescriptions.

Refer to the original measure documentation for additional testing results.

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 SCD convened by Q-METRIC. The Q-METRIC expert panel included nationally recognized experts in SCD, representing hematology, pediatrics, and SCD family advocacy. In addition, measure validity was considered by experts in state Medicaid program operations, health plan quality measurement, health informatics, and health care quality measurement. In total, the Q-METRIC SCD panel included 14 experts, providing a comprehensive perspective on SCD management and the measurement of quality metrics for states and health plans.

The Q-METRIC expert panel concluded that this measure has a very high degree of face validity through a detailed review of concepts and metrics considered to be essential to effective SCD management and treatment. Concepts and draft measures were rated by this group for their relative importance. This measure was among the most highly rated, receiving an average score of 8.5 (with 9 as the highest possible score).

*Validity of Coded Data*. This measure is based on administrative claims data; therefore, the validity of the coded data reported in Medicaid claims was assessed through a medical record review. A subset of SCD cases was identified from Michigan Medicaid claims data, and a chart audit was conducted by trained medical record abstractors to compare administrative data with the corresponding medical record. We conducted a medical chart audit for cases identified in Michigan Medicaid claims for care provided at the three largest centers serving SCD patients in Michigan during 2012: Children's Hospital of Michigan (CHM, Detroit), Hurley Medical Center (HMC, Flint), and the University of Michigan Hospital and Health System (UMHS, Ann Arbor).

Our review indicates that the Medicaid administrative claims have a high degree of agreement with antibiotic prescriptions recorded in medical records abstracted from CHM, HMC, and UMHS. We considered claims within 1 month of the prescription date to accommodate for lags between the date in the medical record indicating that the antibiotic was prescribed versus the actual prescription fill date that is recorded in claims. Among the 35 SCD cases eligible for review for this measure, 34 (97%) of cases identified through medical record review were successfully matched with Michigan Medicaid administrative claims.
data (refer to Table 6 in the original measure documentation); the one case that could not be matched was not enrolled in Medicaid (i.e., did not have a Medicaid ID). Sensitivity was high for identifying antibiotic prescription events using Medicaid administrative claims data; 30/34 (88%) antibiotic prescriptions from the medical record review had a Medicaid administrative claim for an antibiotic within 1 month of the prescription date in the medical record. The positive predictive value of a Medicaid claim for an antibiotic prescription event was 100% (30/30). All eligible cases identified in the medical records had an antibiotic prescription recorded; consequently, the specificity could not be calculated (i.e., undefined due to division by zero).

Evidence for Extent of Measure Testing


State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care
Community Health Care
Hospital Inpatient
Hospital Outpatient
Regional, County, or City Public Health Programs
State/Provincial Public Health Programs

Type of Care Coordination

Coordination between providers and community
Coordination between providers and patient/caregiver

Professionals Involved in Delivery of Health Services

not defined yet
Least Aggregated Level of Services Delivery Addressed
State/Provincial

Statement of Acceptable Minimum Sample Size
Does not apply to this measure

Target Population Age
Age 3 months to 5 years

Target Population Gender
Either male or female

National Framework for Public Health Quality

Public Health Aims for Quality
Population-centered

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim
Healthy People/Healthy Communities

National Quality Strategy Priority
Effective Communication and Care Coordination
Health and Well-being of Communities
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need
Getting Better
Living with Illness
Staying Healthy
IOM Domain

Effectiveness

Data Collection for the Measure

Case Finding Period
The measurement year

Denominator Sampling Frame
Geographically defined

Denominator (Index) Event or Characteristic
Clinical Condition
Encounter
Patient/Individual (Consumer) Characteristic

Denominator Time Window
not defined yet

Denominator Inclusions/Exclusions

Inclusions
The eligible population consists of children in a state aged 90 days or older on January 1 of the measurement year but younger than 5 years on December 31 of the measurement year who are continuously enrolled in Medicaid and received an appropriate sickle cell disease (SCD)-related International Classification of Diseases, Ninth Revision (ICD-9) code on three or more separate health care encounters during the measurement year (refer to Table 1 of the original measure documentation). The designated ICD-9 codes are for sickle cell anemia, which is the most severe form of SCD.

Note: Intake Period: January 1 of the measurement year through December 31 of the measurement year.

Exclusions
Claims in the administrative records for any of the sickle cell disease variants listed in Table 3 of the original measure documentation do not count toward the "three or more separate healthcare encounters" criteria.

Exclusions/Exceptions
not defined yet

Numerator Inclusions/Exclusions
Inclusions
The number of eligible children in a state who received appropriate antibiotic prophylaxis* for at least 350 days, as determined by administrative record review

*Antibiotic Prophylaxis: Any type of penicillin or any type of erythromycin, two doses daily, for the full 350 days (refer to Table 3-A in the original measure documentation). Evidence of antibiotic prophylaxis is determined through administrative records for pharmacy prescriptions filled.

Exclusions
Unspecified

Numerator Search Strategy
Fixed time period or point in time

Data Source
Administrative clinical data

Type of Health State
Does not apply to this measure

Instruments Used and/or Associated with the Measure
Unspecified

Computation of the Measure

Measure Specifies Disaggregation
Does not apply to this measure

Scoring
Rate/Proportion

Interpretation of Score
Desired value is a higher score

Allowance for Patient or Population Factors
not defined yet

Standard of Comparison
not defined yet
Identifying Information

Original Title
Appropriate antibiotic prophylaxis for children with sickle cell disease.

Measure Collection Name
Sickle Cell Disease Measures

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Financial Disclosures/Other Potential Conflicts of Interest
Unspecified

Adaptation
This measure was not adapted from another source.

Date of Most Current Version in NQMC
2013 Dec

Measure Maintenance
Unspecified

Date of Next Anticipated Revision
Unspecified

Measure Status
This is the current release of the measure.
The measure developer reaffirmed the currency of this measure in January 2016.

Measure Availability

For more information, contact Q-METRIC at 300 North Ingalls Street, Room 6C08, SPC 5456, Ann Arbor, MI 48109-5456; Phone: 734-232-0657; Fax: 734-764-2599.

NQMC Status
This NQMC summary was completed by ECRI Institute on July 25, 2014. The information was verified by the measure developer on September 16, 2014.
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Production

Source(s)


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