
CBE ID

3153

Title

Continuity of Primary Care for Children with Medical Complexity

Project

Primary Care and Chronic Illness

Endorsement Status

Endorsement Removed

Is Under Review

No

Previous Endorsement Cycle

Fall 2020

Removal Date

Sun, 07/26/2020 - 00:00

Initial Endorsement

Wed, 07/12/2017 - 11:59

Steward

Seattle Children's Research Institute

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

This measure assesses the percentage of children with medical complexity age 1 to 17 years old who have a Bice-Boxerman continuity of care index (hereafter referred to as Bice-Boxerman COC index) of ≥ 0.5 in the primary care setting over a 12-month period.

1.7 Measure Type

Structure

1.8 Level of Analysis

Health Plan

1.9 Care Setting

Outpatient Services

1.14 Numerator

Number of eligible children(1) who have a Bice-Boxerman COC index ≥ 0.50 in the primary care setting during the measurement year. 1. Eligible children are defined as children who are continuously enrolled for 12 months with no more than a 30-day gap in enrollment. Children with a gap greater than 30 days are excluded because of the potential for them to be enrolled in a different health plan at that time. In such cases, the child's administrative data for the health plan being measured would be incomplete and thus might not reflect the health plan's true performance on the measure. The timeframe of 30 days as the length of the gap was chosen to be consistent with the month-to-month eligibility assessments used by many Medicaid health plans.

1.15 Denominator

Children with medical complexity(1) who are 1-17 years old(2) and who have had ≥ 4 primary care visits(3) during the measurement year. 1. Children with medical complexity are defined as children who are classified by the Pediatric Medical Complexity algorithm, Version 2 (PMCA-V2) as having no chronic illness or non-complex chronic illness. 2. Children must be ≥ 1 year and ≤ 17 years of age on the last day of the measurement year. 3. Research has shown that stability of the COC index increases as the number of visits increases (ie. less subject to significant change as a result of minor variations in care dispersion). (1) We therefore established a minimum of four visits as has been done in previous studies. (1-3) References 1. Christakis DA, Wright JA, Koepsell TD, Emerson S, Connell FA. Is greater continuity of care associated with less emergency department utilization? *Pediatrics*. 1999;103(4 Pt 1):738-742. 2. Christakis DA, Mell L, Koepsell TD, Zimmerman FJ, Connell FA. Association of lower continuity of care with greater risk of emergency department use and hospitalization in children. *Pediatrics*. 2001;107(3):524-529. 3. Tom JO, Tseng C-W, Davis J, Solomon C, Zhou C, Mangione-Smith R. Missed well-child care visits, low continuity of care, and risk of ambulatory care-sensitive hospitalizations in young children. *Arch Pediatr Adolesc Med*. 2010; 11:1052-1058.

1.20 Types of Data Sources

Claims Data

6.1.2 Current or Planned Use(s)

Not in use, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

6.1.3 Current Use(s)

Not in use, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

Planned Use

Quality Improvement (Internal to the specific organization)

Risk Adjustment

No risk adjustment or risk stratification

Steward Organization

Seattle Children's Research Institute

Steward POC email

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