



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 1396

Corresponding Measures:

De.2. Measure Title: Healthy Physical Development by 6 Years of Age

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of children 6 years of age who had healthy physical development services. The measure has four rates: BMI Assessment, Physical Activity Counseling, Nutrition Counseling and Screen Time Counseling.

1b.1. Developer Rationale: Interventions to curb unhealthy habits can improve long-term health. For interventions to be effective, health care providers should individualize advice to meet lifestyles and family life. The measure would encourage BMI assessment followed up by counseling for nutrition, physical activity and screen time as primary prevention practices for all children.

Counseling for Nutrition

Pediatricians may have the best opportunity to make dietary recommendations to parents regarding their child's health.

Age-specific dietary modification is considered to be the cornerstone of treatment. The major goals in dietary management are to provide appropriate calorie intake, provide optimum nutrition for the maintenance of health and normal growth, and to help the child develop and sustain healthful eating habits. Specific dietary guidance regarding fat, carbohydrate and protein intake in children exist.

Counseling for Physical Activity and Screen Time

In terms of counseling for physical activity and reducing sedentary lifestyle, recommendations should focus on engaging in regular physical activity. Guidance on the optimal intensity and duration of physical activity exist.

S.4. Numerator Statement: Children who had healthy physical development services by the time they turned 6 years of age.

S.7. Denominator Statement: Children with a visit who turned 6 years of age in the measurement year.

S.10. Denominator Exclusions: None

De.1. Measure Type: Process

S.23. Data Source: Electronic Health Records, Paper Medical Records

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Aug 15, 2011 **Most Recent Endorsement Date:** Aug 15, 2011

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? This measure appears in the composite measures Comprehensive Well Care by Age 6 Years

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the**

remaining criteria.

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[1396_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Interventions to curb unhealthy habits can improve long-term health. For interventions to be effective, health care providers should individualize advice to meet lifestyles and family life. The measure would encourage BMI assessment followed up by counseling for nutrition, physical activity and screen time as primary prevention practices for all children.

Counseling for Nutrition

Pediatricians may have the best opportunity to make dietary recommendations to parents regarding their child's health.

Age-specific dietary modification is considered to be the cornerstone of treatment. The major goals in dietary management are to provide appropriate calorie intake, provide optimum nutrition for the maintenance of health and normal growth, and to help the child develop and sustain healthful eating habits. Specific dietary guidance regarding fat, carbohydrate and protein intake in children exist.

Counseling for Physical Activity and Screen Time

In terms of counseling for physical activity and reducing sedentary lifestyle, recommendations should focus on engaging in regular physical activity. Guidance on the optimal intensity and duration of physical activity exist.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

There is significant opportunity for improvement in tracking BMI percentiles to determine the rates of diagnosis and treatment for overweight and obesity in children and adolescents. While studies indicate a high burden of overweight among the pediatric population, rates of diagnosis have come to a plateau, and some rates show a decline (Benson, Lacey, 2009). This conflicting information may be a result of missed diagnoses. One study revealed that routine screening with BMI was not documented and that few children received a formal diagnosis or treatment (Dorsey, 2005). Another study showed there was significant undercoding of the diagnosis of obesity; in this study sample, most children with BMIs in the 95th percentile or higher for gender and age did not have a diagnosis of obesity recorded in their medical records (Hampl, 2007).

Nutrition

Children now are consuming unhealthy and less health-beneficial foods. For children 19 to 24 months, French fries were the most common vegetable, 60 percent consumed baked deserts and candy on a given day, and one-third did not consume any fruit on a given day (AHA, 2005).

Physical Activity and Screen Time

About two-thirds of young people in grades nine to 12 do not achieve recommended levels of physical activity. Daily participation in physical education classes dropped from 42 to 33 percent in 1991 (CDC, 2001).

Regarding screen time, less than half of parents watch television with their children, which may lead to a lack of knowledge from parents about the content of the shows and the amount of time spent in front of the television (AAP, 2001). Many parents may not realize the correlation of screen time and a child's excess weight. Physicians can use office visits as a time for intervention (Perrin et al, 2007).

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

American Heart Association. Dietary Recommendations for Children and Adolescents: A Guide for Practitioners: Consensus

Statement From the American Heart Association. Circulation; 112;2061-2075. 2005.

American Academy of Pediatrics, Committee on Public Education. Children, Adolescents, and Television. PEDIATRICS Vol. 107 No. 2 February 2001

Benson, Lacey, Heather J. Baer and David C. Kaelber. Trends in the Diagnosis of Overweight and Obesity in Children and Adolescents: 1999-2007. Pediatrics 2009;123;e153-e158

Dorsey, K.B., C. Wells, H.M. Krumholz, J.C. Concato. Diagnosis, evaluation, and treatment of childhood obesity in pediatric practice. Arch Pediatr Adolesc Med. 2005. July; 159:632-638.

Hampl, S.E., C.A. Carroll, S.D. Simon, V. Sharma. Resource utilization and expenditures for overweight and obese children. Arch Pediatr Adolesc Med. 2007. Jan; 161:11-14.

Centers for Disease Control and Prevention (CDC). Physical activity and good nutrition: essential elements to prevent chronic diseases and obesity. Atlanta (GA); National Center for Chronic Disease Prevention and Health Promotion; 2007 April. 1-4 pgs.

Perrin, EM, et al. Obesity prevention and the primary care pediatrician's office. Current Opinion in Pediatrics. 19:354-361. June 2007.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

While obesity and overweight are prevalent in children and adolescents of all ethnic groups, there is significant variation among these groups. Obesity is most disproportionately prevalent among Hispanic, African Americans, and Native-American children and adolescents. Among males, the highest prevalence is among Mexican Americans; among females, the highest is in African Americans. In a ten-year study investigating the development of obesity in a cohort of 2,379 girls during adolescence, the prevalence of obesity at age nine was twice as high among African American girls (18 percent), compared with white girls (8 percent) (Kimm, 2002). Other disparities are found in children whose parents are obese, children with a sibling who is obese, children from low-income families, and children with a chronic disease or disability that limits mobility (Hagan, 2008). Educational level and language spoken may also be correlated with obesity. A seminal study found that, of the children entering kindergarten, those whose mothers had not attained a bachelor's degree and those from homes where the primary language spoken was not English were at a higher risk for an increased BMI (High, 2008).

Nutrition

Food insecurity, where there is little money to pay for healthy food, can be one cause of poor diet. Food insecurity impacts different socio-economic classes and thus leads to worse health for children from poorer families (Hagan, 2008). Children that are fed through WIC are much more likely to have an unhealthy diet (National Academy of Sciences). The Department of Health and Human Services found that, in 2003, food insecurity among black non-Hispanic, Hispanic, and American Indian or Alaska Native households was nearly three times that of white non-Hispanic households. In addition, the proportion of lower-income households that experienced food insecurity was more than four times that of higher-income households (Daniels, 2005). The American Heart Association recommends pediatricians account for a child's culture and family situation when making dietary recommendations.

Physical Activity and Screen Time

Racial/ethnic disparities exist in the amount of participation in physical activities. Whites in grades 9-12 had the best rates for moderate and vigorous regular physical activity. Hispanics/Latinos and African Americans in grades 9-12 had the lowest amount of participation in moderate and vigorous regular physical activity. However Hispanics/Latinos had the highest rates of participation in physical activity in school and in physical education class. African Americans have a low rate of participation in physical activity in school, and whites had a low rate of participation in physical education class. Boys in grades 9 through 12 had higher rates of physical activity, daily physical activity in school, and participation in physical education class compared to females.

In regards to television viewing among 9th through 12th graders, whites had the best (lowest) rate, Hispanics next, and African Americans with the highest (worst) rate of television viewing. Females in grades 9 through 12 had better rates of television viewing.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

American Heart Association. Dietary Recommendations for Children and Adolescents: A Guide for Practitioners: Consensus Statement From the American Heart Association. *Circulation*; 112;2061-2075. 2005.

Hagan, JF, Shaw JS, Duncan PM, eds. 2008. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition. Elk Grove, IL: American Academy of Pediatrics.

High, Pamela C. and the Committee on Early Childhood, Adoption, and Dependent Care and Council on School Health. School Readiness. *Pediatrics* 2008;121:e1008-e1015

Kimm, S.Y.S., B.A. Barton, E. Obarzanek, et al. Obesity development during adolescence in a biracial cohort: the NHLBI growth and health study. *Pediatrics* 2002; 110(5). www.pediatrics.org/cgi/content/full/110/5/e54

Kaplan, Jeffrey P et al. In Preventing Childhood Obesity: Health in the Balance. Ed. Washington, DC: National Academy of Sciences. 2005.

U.S. Department of Health and Human Services. Healthy People 2010: Midcourse Review. 2nd ed. Washington, DC: U.S. Government Printing Office

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, A leading cause of morbidity/mortality, Severity of illness, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

One of the most challenging developments in pediatrics in the past two decades has been the emergence of a new chronic condition: overweight and obesity in childhood and adolescence. In the past 30 years, the prevalence of overweight and obesity has increased sharply for children. Overweight is defined as having a body mass index (BMI) greater than the 85th percentile but lower than the 95th percentile for age and sex. Obese is defined as BMI greater than the 95th percentile for age and sex (Benson et al, 2009)

Among young people, the prevalence of overweight increased from five to 14 percent for those aged two to five years, six and a half to 19 percent for those aged six to 11 years, and five to 17 percent for those aged 12–19 years (Hagan et al, 2008). National Health and Nutrition Examination Survey (NHANES) data from Cycle II (1976–1980) and Cycle III (1988–1994) document an increase in the prevalence of obesity in all age, ethnic, and gender groups, and data collected from 1999–2000 revealed a continued increase in the number of obese children (Fox et al, 2006).

The prevalence of obesity in childhood is significant, as overweight children and adolescents are more likely to become obese as adolescents and as adults (CDC, 2007; Hagan et al, 2008). One study found that approximately 80 percent of children who were overweight at age ten to 15 years were obese adults at age 25 (Whitaker, 1997). Another study found that of the children studied, 12 percent of boys and 11 percent of girls in kindergarten were at risk of overweight (High, 2008). Recent studies indicate that a child's weight at five years old is more accurately predictive of their future weight than their gestational weight, as previously believed. Pre-school aged children who reached the 50th percentile for BMI anytime during preschool were six times more likely to be overweight later in childhood; those children in the top rung of BMI percentiles at age five become the heaviest nine-year olds (Gardner, et al, 2009). Another study found that if overweight begins before age eight, obesity in adulthood is likely to be more severe (Freedman, 2001).

The economic costs of obesity and related comorbidities have been estimated at over \$70 billion, or seven percent of the national health care budget. One estimate suggests that obesity-associated inpatient or hospitalization costs have risen threefold, from \$35 million (1979–1981) to \$127 million (1997–1999). Furthermore, hospital utilization reflects only a portion of the burden of care for overweight and obese children (Dietz, 2002).

1c.4. Citations for data demonstrating high priority provided in 1a.3

American Academy of Pediatrics, Committee on Public Education. Children, Adolescents, and Television. PEDIATRICS Vol. 107 No. 2 February 2001

American Heart Association. Dietary Recommendations for Children and Adolescents: A Guide for Practitioners: Consensus Statement From the American Heart Association. Circulation; 112;2061-2075. 2005.

Benson L, Baer HJ, Kaelber DC. Trends in the Diagnosis of Overweight and Obesity in Children and Adolescents: 1999_2007. Pediatrics 2009;123;e153-e158

Centers for Disease Control and Prevention. Physical activity and good nutrition: essential elements to prevent chronic diseases and obesity. Atlanta (GA); National Center for Chronic Disease Prevention and Health Promotion; 2007 April. 1-4 pgs.

Dietz W.H., G. Wang. Economic burden of obesity in youths aged 6 to 17 years: 1979–1999. Pediatrics 2002; 109:e81.

Federal Trade Commission, Bureau of Economics State Report. Children’s Exposure to TV Advertising in 1977 and 2004 Information for the Obesity Debate. June 2001. <http://www.ftc.gov/os/2007/06/cabecolor.pdf>

Fox, CS, et al. Trends in the Incidence of Type 2 Diabetes Mellitus From the 1970s to the 1990s. The Framingham Heart Study. Circulation. June 2006.

Freedman, D.S., L.K. Khan, W.H. Dietz, S.R. Srinivasan, G.S. Berenson. Relationship of childhood overweight to coronary heart disease risk factors in adulthood: The Bogalusa Heart Study. Pediatrics. 2001; 108:712–718.

Gardner, Daphne S. L., et al. Contribution of Early Weight Gain to Childhood Overweight and Metabolic Health: A Longitudinal Study (EarlyBird 36). Pediatrics 2009;123;e67-e73

Hagan, JF, Shaw JS, Duncan PM, eds. 2008. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition. Elk Grove, IL: American Academy of Pediatrics.

High, Pamela C. and the Committee on Early Childhood, Adoption, and Dependent Care and Council on School Health. School Readiness. Pediatrics 2008;121;e1008-e1015

Kaplan, Jeffrey P, et al. Ed. In Preventing Childhood Obesity: Health in the Balance. Ed. Washington, DC: National Academy of Sciences. 2005.

Perrin, EM, et al. Obesity prevention and the primary care pediatrician’s office. Current Opinion in Pediatrics. 19:354–361. June 2007.

U.S. Department of Health and Human Services. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: US Government Printing Office, Nov 2000.

U.S. Preventive Services Task Force. Screening and interventions for overweight in children and adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005. 11 p.

Whitaker, R.C., J.A. Wright, M.S. Pepe, K.D. Seidel, W.H. Dietz. Predicting obesity in young adulthood from childhood and parental obesity. N Engl J Med. 1997. 37(13):869–873

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide

evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific (check all the areas that apply):

Health and Functional Status : [Change](#)

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

[This is not an eMeasure](#) Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

[No data dictionary](#) Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Children who had healthy physical development services by the time they turned 6 years of age.](#)

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Numerator: 2 years

Denominator: 1 year

S.6. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Children who had the following healthy physical development services by the time they turned 6 years of age: BMI Assessment, Physical Activity Counseling, Nutrition Counseling, Screen Time Counseling](#)

Report each rate separately.

Rate 1. BMI Assessment:

Documentation must include a note indicating at least one of the following.

- BMI percentile, or
- BMI percentile plotted on age-growth chart

Rate 2. Physical Activity Counseling:

Documentation must include a note indicating at least one of the following.

- Engagement in discussion of current physical activity behaviors (e.g. exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating that physical activity was addressed
- Counseling or referral for physical activity
- Patient received educational materials on physical activity
- Anticipatory guidance for physical activity

Rate 3: Nutrition Counseling

Documentation must include a note indicating at least one of the following.

- Engagement in discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating that nutrition was addressed
- Counseling or referral for nutrition education
- Patient received educational materials on nutrition
- Anticipatory guidance for nutrition

Rate 4. Screen Time Counseling:

Documentation must include a note indicating at least one of the following.

- Engagement in discussion of current screen-watching behaviors (e.g. type of screen activity, amount of time sitting inactive in front of computer or television, appropriate screen activity, supervision of screen activity)
- Checklist indicating that screen time was addressed
- Patient received educational materials on screen time
- Anticipatory guidance for screen time

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

Children with a visit who turned 6 years of age in the measurement year.

S.8. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

Children

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Children who turned 6 years of age during the measurement year and who had documentation of a face-to-face visit between the clinician and the child that predates the child's birthday by at least 12 months.

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

None

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

NA

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

None

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

NA

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)

Step 1: Determine the denominator

Children who turned the requisite age in the measurement year, AND

Who had a visit within the past 12 months of the child's birthday

Step 2: Determine the numerator

Children who had documentation in the medical record of the screening or service during the measurement year or the year previous to the measurement year.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

For this physician-level measure, we anticipate the entire population will be used in the denominator. If a sample is used, a random sample is ideal. NCQA's work has indicated that a sample size of 30-50 patients would be necessary for a typical practice size of 2000 patients.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check *ONLY* the sources for which the measure is *SPECIFIED AND TESTED*).

If other, please describe in S.24.

[Electronic Health Records](#), [Paper Medical Records](#)

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

[Medical Record](#)

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check *ONLY* the levels of analysis for which the measure is *SPECIFIED AND TESTED*)

[Clinician : Group/Practice](#), [Clinician : Individual](#)

S.27. Care Setting (Check *ONLY* the settings for which the measure is *SPECIFIED AND TESTED*)

[Outpatient Services](#)

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[1396_MeasureTesting_MSF5.0_Data.doc](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition,](#)
[Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\)](#)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

[No](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

[NCQA plans to eventually specify this measure for electronic health records.](#)

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

Based on field test results, we have specified the measure to assess whether screening was documented and whether use of a standardized tool was documented. Our field test results showed that these data elements are available in the medical record. In addition, our field test participants noted that many were able to program these requirements into their electronic health record systems, and several implemented point-of-service physician reminders for this measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

During the measure development process the Child Health MAP and measure development team worked with NCQA's certified auditors and audit department to ensure that the measure specifications were clear and auditable. The denominator, numerator and any exclusions are concisely specified and align with our audit standards.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;
OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [National Committee for Quality Assurance](#)

Co.2 Point of Contact: [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

Co.4 Point of Contact: [Jill Marie, Farrell, \[farrell@ncqa.org\]\(mailto:farrell@ncqa.org\), 202-955-1785-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[Child Health Measurement Advisory Panel:](#)

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Michael Siegal Jessie Sullivan
Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? Ad.5 When is the next scheduled review/update for this measure?
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