



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 #: 1399

Corresponding Measures:

De.2. Measure Title: Developmental Screening in the First Three Years of Life

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

De.3. Brief Description of Measure: The percentage of children ages one, two and three years who had a developmental screening performed.

Three rates are reported:

Rate 1: Developmental Screening by the Child's First Birthday

Rate 2: Developmental Screening by the Child's Second Birthday

Rate 3: Developmental Screening by the Child's Third Birthday

1b.1. Developer Rationale: Pediatricians are not usually successful in identifying children with developmental delays without use of a standardized tool (Hix-Small, 2007). This measure will encourage the use of standardized tools for developmental screening, as delineated by guidelines. Children who are identified earlier are more likely to have developmental promotion activities, that can further improve the likelihood that they will be able to start school ready to learn. Demonstrated quality improvement activities such as the ABCD Screening Academy have shown that providers can feasibly and sustainably implement standardized screening, and when done so, more children are referred to Early Intervention and other services and that the kinds and types of referrals performed are more appropriate than was previously done without standardized screening.

S.4. Numerator Statement: Children who had documentation of a developmental screening (screening for risk of developmental, behavioral and social delays) using a standardized tool by their first, second and third birthdays.

S.7. Denominator Statement: Children with a visit who turned one, two and three years of age.

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 Comprehensive Well Care by Age 2 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

[1399_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)

Pediatricians are not usually successful in identifying children with developmental delays without use of a standardized tool (Hix-Small, 2007). This measure will encourage the use of standardized tools for developmental screening, as delineated by guidelines. Children who are identified earlier are more likely to have developmental promotion activities, that can further improve the likelihood that they will be able to start school ready to learn. Demonstrated quality improvement activities such as the ABCD Screening Academy have shown that providers can feasibly and sustainably implement standardized screening, and when done so, more children are referred to Early Intervention and other services and that the kinds and types of referrals performed are more appropriate than was previously done without standardized screening.

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.

Findings from the National Survey of Children Health show that only 19.5% of children are screened in the first five years of life. Despite the evidence, the use of standardized developmental screening tools is uncommon; only about 20 percent of physicians routinely use developmental screening tests (The Commonwealth Fund, 2008). One study found that pediatricians failed to identify and refer 60 to 80 percent of children with developmental delays in a timely manner. Another study found that 68 percent of children with delays were not detected by pediatricians. Though many significant delays occur before school age, less than 50 percent of children with delays are identified before starting school -- leading to missed opportunities for treatment (Hix-Small, 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.

<http://www.nschdata.org>

Commonwealth Fund. Quality Matters, May 6 2008.

Hix-Small, Hollie, PhD, et al. Impact of Implementing Developmental Screening at 12 and 24 Months in a Pediatric Practice Pediatrics Vol. 120 No. 2 August 2007, pp. 381-389

Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006;118(1):405-420

The American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental and Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs. Identifying infants and young children with developmental disorder in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006. 118(1): 405-420.

Bethell, CD, Reuland, C, Halfon, N, Olsen, L, Schor, E., Measuring the Quality of Preventive and Developmental Services for Young Children: National Estimates and Patterns of Clinicians' Performance. Pediatrics. June 2004.

Pinto-martin, J, Dunkle M, Earls M, Fliedner D, Cynthia L. Developmental States of Developmental Screening: Steps to Implementation of a Successful Program. American Journal of Public Health. 95, 11: 1928-1932.

King T., Trandon, D, Macias, M, et al. Implementing developmental screening and referrals: Lessons learned from a national project. Pediatrics, V 125, No 2, Feb 2010.

Sand N, Silverstein M, Glascoe FP, et al. Pediatrician's reported practices regarding developmental screening: do guidelines work? Do they help? Pediatrics 2005; V116 (1): 174-179

Smith RD. The use of developmental screening tests by primary-care pediatricians. J Pediatrics. 1978; 93(3): 524-527.

Zuckerman KE, Boudreau AA, Lipstein EA, Kuhlthau KA, and Perrin JM. Household Language, Parent Developmental Concerns, and Child Risk for Developmental Disorder. Academic Pediatrics. 2009; 9(2): 97-105.

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.*

Studies suggest income disparities exist for developmental screening. One study found that only 23 percent of low-income children receive recommended preventive and developmental services (Bethell et al, 2002). The Early Intervention Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for Medicaid children includes screening at each visit, however, as of 2007, 28 states were engaged in lawsuits due to a failure to properly deliver this service (Glascoe et al, 2007). Another study found that children most at risk for school difficulty were those whose mothers had less than a high school education, those who came from single-mother families, those who had received public assistance, and those who lived in families in which the primary language was not English (High, 2008).¹ Specific ally related to screening, the National Survey of Children's Health found that while improvements were needed in increasing screening for all children, significant variations existed in the rates of screening by race-ethnicity and insurance status.

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.

Bethell at al. Partnering with parents to promote the healthy development of young children enrolled in Medicaid. New York NY: The commonwealth Fund, 2002.

Glascoe FP, PhD and Shapiro, HL, MD. Introduction to Developmental and Behavioral Screening. 2007.

<http://www.dbpeds.org/articles/detail.cfm?TextID=5>

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

<http://www.nschdata.org>

Pinto-martin, J, Dunkle M, Earls M, Fliedner D, Cynthia L. Developmental States of Developmental Screening: Steps to Implementation of a Successful Program. American Journal of Public Health. 95, 11: 1928-1932.

King T., Trandon, D, Macias, M, et al. Implementing developmental screening and referrals: Lessons learned from a national project. Pediatrics, V 125, No 2, Feb 2010.

Sand N, Silverstein M, Glascoe FP, et al. Pediatrician's reported practices regarding developmental screening: do guidelines work? Do they help? Pediatrics 2005; V116 (1): 174-179

Smith RD. The use of developmental screening tests by primary-care pediatricians. J Pediatrics. 1978; 93(3): 524-527.

Zuckerman KE, Boudreau AA, Lipstein EA, Kuhlthau KA, and Perrin JM. Household Language, Parent Developmental Concerns, and Child Risk for Developmental Disorder. Academic Pediatrics. 2009; 9(2): 97-105.

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

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.

The American Academy of Pediatrics (AAP) defines a developmental delay as a “condition in which a child is not developing and/or achieving skills according to the expected time frame.” A child that is developmentally challenged may face many barriers throughout life; these barriers are even more severe if a delay in development is not detected early. Delayed or disordered development can lead to further health and behavior problems, including failure in school and social and emotional problems.(Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee, 2006) Approximately 12 to 18 percent of U.S. children may have a developmental and behavioral problem. However, only about two percent of children from birth to two years old receive the necessary early intervention services.(Hix-Small, Hollie, PhD, et al., 2007)

A child who is identified as having a delay in development by the time he starts school and participates in early intervention programs is more likely to graduate high school, hold a job, live independently, and avoid teen pregnancy, delinquency and violent crimes -- representing a saved cost to society of between \$30,000 and \$100,000 per child.(Glascoe FP, PhD, et al., 2007)

Studies have shown that developmental surveillance based on non-standardized clinical judgment and observation alone does not accurately identify children with delays. Therefore, national recommendations call for routine, standardized screening of children three times in the first three years (at the 9, 18 and 24-or 30-month well-visit).

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

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

Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006;118(1):405-420

Hix-Small, Hollie, PhD, et al. Impact of Implementing Developmental Screening at 12 and 24 Months in a Pediatric Practice Pediatrics Vol. 120 No. 2 August 2007, pp. 381-389

Glascoe FP, PhD and Shapiro, HL, MD. Introduction to Developmental and Behavioral Screening. 2007.
<http://www.dbpeds.org/articles/detail.cfm?TextID=5>

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):

Primary Prevention

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 documentation of a developmental screening (screening for risk of developmental, behavioral and social delays) using a standardized tool by their first, second and third birthdays.

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.)

The measurement year (12 month period)

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.

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed
- The standardized tool used
- Evidence the tool was completed and scored

The following tools meet criteria* for a standardize tool. Only the tools listed here will meet numerator compliance for this measure.

Rate 1: Developmental Screening Conducted Between Age 0 and <= 1 Year

Ages and Stages Questionnaire (ASQ) (Age 2 Months to 5 Years)

Ages and Stages Questionnaire - 3rd edition (ASQ-3) (Age 1 Month to 5.5 Years)

Battelle Developmental Inventory Screening Tool (BDI-ST) (Age Birth to 95 Months)

Bayley Infant Neuro-developmental Screen (BINS) (Age 3 Months to 2 Years)

Brigance Screens-II (Age Birth to 90 Months)

Child Development Inventory (CDI)

Infant Development Inventory (Age Birth to 18 Months)

Parents' Evaluation of Developmental Status (PEDS) (Age Birth to 8 Years)

Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) (Age Birth to 8 Years)

Rate 2: Developmental Screening Conducted Between Age >1 Year and <= 2 Years

Ages and Stages Questionnaire (ASQ) (Age 2 Months to 5 Years)

Ages and Stages Questionnaire - 3rd edition (ASQ-3) (Age 1 Month to 5.5 Years)

Battelle Developmental Inventory Screening Tool (BDI-ST) (Age Birth to 95 Months)

Bayley Infant Neuro-developmental Screen (BINS) (Age 3 Months to 2 Years)

Brigance Screens-II (Age Birth to 90 Months)

Child Development Inventory (18 Months to 6 Years)

Infant Development Inventory (Age Birth to 18 Months)

Parents' Evaluation of Developmental Status (PEDS) (Age Birth to 8 Years)

Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) (Age Birth to 8 Years)

Rate 3: Developmental Screening Conducted Between Age >2 Years and <= 3 Years

Ages and Stages Questionnaire (ASQ) (Age 2 Months to 5 Years)

Ages and Stages Questionnaire - 3rd edition (ASQ-3) (Age 1 Month to 5.5 Years)

Battelle Developmental Inventory Screening Tool (BDI-ST) (Age Birth to 95 Months)

Brigance Screens-II (Age Birth to 90 Months)

Child Development Inventory (18 Months to 6 Years)

Parents' Evaluation of Developmental Status (PEDS) (Age Birth to 8 Years)

Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) (Age Birth to 8 Years)

Tools NOT Included in This Measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above, as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

* The following criteria were used to define a standardized tool for this measure

1) Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.

2) Established Reliability: Reliability scores of 0.70 or above.

3) Established Findings Regarding the Validity:

- Concurrent validity: This compares screening results with outcomes derived from a reliable and valid diagnostic assessment usually performed 7-10 days after the screening test. The validity coefficient reports the agreement between the two tests (Meisels & Atkins-Burnett, 2005).

- Predictive validity: This compares the screening results with measures of children's performance obtained 9-12 months later (Meisels & Atkins-Burnett, 2005).

Validity scores for the tool must be 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

4) Established Sensitivity and Specificity: Sensitivity and specificity scores of 0.70 or above.

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

Children with a visit who turned one, two and three years of age.

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)

Rate 1: Children who turned 1 year of age during the measurement year and 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.

Rate 2: Children who turned 2 years of age during the measurement year and 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.

Rate 3: Children who turned 3 years of age during the measurement year and 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 2 years of age in the measurement year, AND

Who had a visit that predates the child's birthday by at least 12 months

Step 2: Determine the numerator

Children who had documentation in the medical record of developmental screening using a standardized tool at least 12 months predating the child's 2-year birthday.

Documentation must include a note indicating the standardized tool that was used, the date of screening and evidence that the tool was completed and scored. Only tools used on the specified list may count as a standardized tool.

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

1399_MeasureTesting_MS5.0_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 adapt this measure for use in 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 with 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.

In working with CAHMI on the state-level measure, we worked to ensure our age ranges and requirements for a standardized tool were consistent in responding to state experiences.

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.)

NA

Related Measures: 0011

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:](#)

[Jeanne Alicandro](#)
[Barbara Dailey](#)
[Denise Dougherty, PhD](#)
[Ted Ganiats, MD](#)
[Foster Gesten, MD](#)
[Nikki Highsmith, MPA](#)
[Charlie Homer, MD, MPH](#)
[Jeff Kamil, MD](#)
[Elizabeth Siteman](#)
[Mary McIntyre, MD, MPH](#)
[Virginia Moyer, MD, MPH, FAAP](#)
[Lee Partridge](#)
[Xavier Sevilla, MD, FAAP](#)
[Michael Siegal, MD](#)
[Janet Sullivan, MD](#)

[The NCQA Child Health MAP advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts, including representatives from pediatricians, family physicians, researchers, Medicaid CHIP offices and health plans.](#)

[Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the Child Health MAP.](#)

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?

Ad.6 Copyright statement: [© 2009 by the National Committee for Quality Assurance](#)

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[Washington, DC 20005](#)

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: