



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 #: 1553

Corresponding Measures:

De.2. Measure Title: Blood Pressure Screening by 18 Years of Age

Co.1.1. Measure Steward:

De.3. Brief Description of Measure: The percentage of adolescents 18 years of age who had a blood pressure screening with results during the measurement or the year prior to the measurement year.

1b.1. Developer Rationale: If hypertension is detected early, children can be monitored and treated, which can lead to a normal and healthy life. If not detected or treated, hypertension can lead to damage of the eyes, heart, kidneys, and brain. In addition, high blood pressure can put children at a higher risk for heart attacks, strokes, kidney failure, and a hardening of the arteries (atherosclerosis) (The Nemours Foundation, 2005). Doctors may discover high blood pressure during a regular blood pressure screening. An early diagnosis and treatment leads to a better prognosis. Blood pressure screening can save lives by starting treatment well before the patient was aware of a problem.

S.4. Numerator Statement: Adolescents who had documentation of a blood pressure screening and whether results are abnormal at least once in the measurement year or the year prior to the measurement year.

S.7. Denominator Statement: Adolescents with a visit who turned 18 years old 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 Comprehensive Well Care by Age 18 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
1553_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)

If hypertension is detected early, children can be monitored and treated, which can lead to a normal and healthy life. If not detected or treated, hypertension can lead to damage of the eyes, heart, kidneys, and brain. In addition, high blood pressure can put children at a higher risk for heart attacks, strokes, kidney failure, and a hardening of the arteries (atherosclerosis) (The Nemours Foundation, 2005). Doctors may discover high blood pressure during a regular blood pressure screening. An early diagnosis and treatment leads to a better prognosis. Blood pressure screening can save lives by starting treatment well before the patient was aware of a problem.

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.

Despite the importance of measurement and treatment, one study found that almost three quarters of children diagnosed with hypertension did not have a diagnosis of high blood pressure in the electronic medical record; this led to undiagnosed hypertension for 75 percent of the children in this study (Hansen, 2007). Moreover, studies have found that hypertension and prehypertension were frequently undiagnosed in this pediatric population (Hansen, 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.

The Nemours Foundation. High Blood Pressure (Hypertension). <http://kidshealth.org/parent/medical/heart/hypertension.html>. Updated: October 2005

Hansen, ML, MD, et al. Underdiagnosis of Hypertension in Children and Adolescents. Journal of the American Medical Association, Vol 298, No. 8. August 22/29, 2007

Hansen ML, Gunn PW, Kaelber DC. Underdiagnosis of Hypertension in Children and Adolescents. JAMA. Vol. 298 No. 8, August 22/29, 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.

Major racial/ethnic disparities exist among those with hypertension. One study using national surveys found that an ethnic and gender gap appeared for pre-high blood pressure in 1988 and for high blood pressure in 1999 among children aged eight to 17 years: non-Hispanic blacks and Mexican Americans had a greater prevalence of both high blood pressure and pre-high blood pressure than non-Hispanic whites, and males had a greater prevalence than females (Din-Dzietham R, 2007). Studies suggest that racial differences in blood pressure control rates among those treated cannot be explained by nonpharmacologic management or health insurance, but there is some association with educational attainment (Robin P. Hertz, 2005).

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.

Din-Dzietham R, Liu Y, Bielo M, Shamsa F. High blood pressure trends in children and adolescents in national surveys, 1963-2002. Circulation Vol 116(13): 1488. Sep 2007.

Robin P. Hertz, PhD; Alan N. Unger, PhD; Jeffrey A. Cornell, MS; Elijah Saunders, MD. Racial Disparities in Hypertension Prevalence, Awareness, and Management. Arch Intern Med. 2005;165:2098-2104.

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, High resource use, 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.

High blood pressure (hypertension) is a growing concern for children and adolescents in the U.S., due mostly in part to a rapid increase in childhood obesity (Luma, 2006). A recent study of National Health and Nutrition Examination Survey data showed that, during 2003-2006, 2.6 percent of boys and 3.4 percent of girls age eight to 17 years had high blood pressure. Moreover, 13.6 percent of boys and 5.7 percent of girls in this age group had pre-high blood pressure. Overweight boys and obese boys and girls were significantly more likely to have these classifications (Ostchega Y, 2009). Autopsy reports of children and adolescents who have died unexpectedly have shown a positive and significant association with systolic and diastolic blood pressure and body mass index (BMI) (Hayman, 2003). Autopsy reports of adults with high levels of cholesterol and coronary heart disease showed that precursors to these diseases began in childhood (National Cholesterol Education Program).

High blood pressure represents a significant financial burden. In 2006, the direct and indirect costs of high blood pressure were estimated at \$63.5 billion overall (CDC, 2007). In addition to costs, resource utilization is also significantly higher among hypertensive people. Prescription medicines, inpatient visits, and outpatient visits constitute more than 90 percent of the overall incremental cost of treating hypertension (Balu, 2005). These costs can be expected to rise with increasing prevalence among children.

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

Balu, Sanjeev. Incremental cost of treating hypertension in the United States. <http://docs.lib.purdue.edu/dissertations/AAI3191421/>. Updated 2005.

Centers for Disease Control and Prevention. High Blood Pressure Facts. <http://www.cdc.gov/bloodpressure/facts.htm>. Updated February 2007.

L. Hayman and Kathryn Taubert Rae-Ellen W. Kavey, Stephen R. Daniels, Ronald M. Lauer, Dianne L. Atkins, Laura American Heart Association Guidelines for Primary Prevention of Atherosclerotic Cardiovascular Disease Beginning in Childhood. *Circulation* 2003;107;1562-1566. <http://www.circ.ahajournals.org/cgi/reprint/107/11/1562>

Luma, GB, MD and Spiotta RT, MD. Hypertension in Children and Adolescents. *American Family Physician*; Vol 73, Number 9. May, 2006

National Cholesterol Education Program. Overview and Summary. *Pediatrics*; Mar92 Part 2, Vol. 89 Issue 3, p525. <http://web.ebscohost.com.proxygw.wrlc.org/ehost/pdf?vid=3&hid=8&sid=d3fa709d-0a3b-42ab-8371-6416129fe41f%40sessionmgr3>

National Heart, Lung and Blood Institute. National Institutes of Health. High Blood Pressure. Nov 2008. http://www.nhlbi.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html

The Nemours Foundation. High Blood Pressure (Hypertension). <http://kidshealth.org/parent/medical/heart/hypertension.html>. Updated: October 2005

Ostchega Y, Carroll M, Prineas RJ, McDowell MA, Louis T, Tilert T. Trends of elevated blood pressure among children and adolescents: data from the National Health and Nutrition Examination Survey 1988-2006. *Am J Hypertension*. Vol 22(1): 59-67. Jan 2009.

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.

Adolescents who had documentation of a blood pressure screening and whether results are abnormal at least once in the measurement year or the year prior to the measurement year.

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: 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 of a blood pressure percentile, the date of the blood pressure screening, both diastolic and systolic results, and whether the results are abnormal (defined as >95th percentile for age/gender/height based on NHLBI published norms) during the measurement year or the year prior to the measurement year.

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

Adolescents with a visit who turned 18 years old 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)*

Adolescents who turned 18 years of age during the measurement year and who had documentation of a face-to-face visit between the clinician and the adolescent that predates the adolescent'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

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

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

Step 2: Determine the numerator

Adolescents 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

1553_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 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 optional 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): Co.2 Point of Contact: Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance Co.4 Point of Contact: Rita, Lewis, lewis@ncqa.org, 202-955-5102-
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
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 1100 13th Street, NW, Suite 1000 Washington, DC 20005 Ad.7 Disclaimers:
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