

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the [evaluation criteria](#) are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: 1395	NQF Project: Child Health Quality Measures 2010
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: Chlamydia Screening and Follow Up	
De.2 Brief description of measure: The percentage of female adolescents who turned 18 years old during the measurement year and who had a chlamydia screening and proper follow-up visit.	
1.1-2 Type of Measure: Process	
De.3 If included in a composite or paired with another measure, please identify composite or paired measure This measure appears in the composite Comprehensive Well Care by Age 18 Years	
De.4 National Priority Partners Priority Area: Care coordination, Population health	
De.5 IOM Quality Domain: Effectiveness, Timeliness	
De.6 Consumer Care Need: Staying healthy	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i> A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): Proprietary measure A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission A.4 Measure Steward Agreement attached:	A Y <input type="checkbox"/> N <input type="checkbox"/>
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and	B

update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: Public reporting, Internal quality improvement Accountability	C Y <input type="checkbox"/> N <input type="checkbox"/>
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (issues or questions regarding any criteria):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria) 1a. High Impact	Eval Ratin g
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Leading cause of morbidity/mortality, High resource use, Severity of illness, Patient/societal consequences of poor quality 1a.2 1a.3 Summary of Evidence of High Impact: Chlamydia trachomatis is the most common sexually transmitted bacterial infection in the US (USPSTF, 2006). Among women with chlamydial infection, 20-40 percent will experience pelvic inflammatory disease (Mangione-Smith, 1999), 50-75 percent will experience tubal factor infertility if untreated (Mangione-Smith, 1999; Sellors, 1998), and 65 percent will experience an ectopic pregnancy if untreated. It is the leading cause of preventable infertility and, among other adverse pregnancy related problems, can cause preterm birth, miscarriages, infant mortality, and neonatal chlamydial infections (USPSTF, 2007). Over 900,000 chlamydial infections were reported to the Centers for Disease Control and Prevention (CDC) from 50 states and the District of Columbia in 2004. Since many cases are not reported or even diagnosed, it is estimated that there are actually 2.8 million new cases of chlamydia each year (Weinstock, 2004). From 1987 through 2004, the reported rate of chlamydial infection in women increased from 78.5 cases to 485.0 cases per 100,000 people. A portion of the increase in prevalence is attributed to continued expansion of chlamydia screening programs (CDC, 2005). Cost-effectiveness data of Chlamydia screening found that routinely screening women younger than age 25 saves \$45 for every woman screened (Mangione-Smith, 1999). The CDC estimated that every dollar spent on	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

Chlamydia testing and treatment saves \$12 in complications arising from untreated Chlamydia (CDC, 2001). Studies suggest the most cost- effective screening interval is yearly screening for women aged 15-29 followed by screening every 6 months for those with a history of infection (Hu, 2004).

1a.4 Citations for Evidence of High Impact: Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2004 Supplement, Chlamydia Prevalence Monitoring Project. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, December 2005.

Centers for Disease Control and Prevention. Chlamydia in the United States. April 2001b.

Hu, Delphine, MD, et al. Screening for Chlamydia trachomatis in Women 15 to 29 Years of Age: A Cost-Effectiveness Analysis. Annals of Internal Medicine. October 5, 2004. Volume 141: 501-513.

Humphreys JT, Henneberry JF, Rickard RS, Beebe JL. Cost-benefit analysis of selective screening criteria for Chlamydia trachomatis infection in women attending Colorado family planning clinics. Sex Transm Dis 1992, 19:47-53.

Mangione-Smith R, O’Leary J, McGlynn EA. Health and cost-benefits of chlamydia screening in young women. Sexually Transmitted Diseases: Vol 26(6) July 1999 pg 302-316.

Sellers JW, Mahony JB, Cherneski MA, Rath DJ. Tubal factor infertility: an association with prior chlamydia infection and asymptomatic salpingitis. Fertility and Sterility 1998;49:451-457.

U.S. Preventive Services Task Force. Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2007 Jul 17;147(2):128-34

Weinstock H, Berman S, Cates W. Sexually Transmitted Diseases Among American Youth: Incidence and Prevalence Estimates, 2000. Perspectives on Sexual and Reproductive Health 2004;36(1):6-10.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Most individuals infected with chlamydia are asymptomatic. Screening is necessary to detect cases and to reduce the risk of complications. This measure encourages secondary prevention of chlamydia.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

Despite the widespread availability of non-invasive testing methods for chlamydia and single dose therapy using azithromycin, chlamydia screening rates have, overall, remained low (Fairley, 2005). This rate may reflect barriers to testing that relate to both patients and health care providers. For instance, adolescents may be reluctant to seek care for their sexual health because of embarrassment or concerns about their confidentiality, while health care providers may have limited awareness of chlamydia as an issue or lack the time, knowledge and skills to manage and discuss sexual health issues (Verhoeven, 2005; Poljski, 2004).

1b.3 Citations for data on performance gap:

Fairley CK, Hocking , Gunn J, Chen MY: No barriers to chlamydia testing in sexually active young women. Med J Aust 2005 , 183:548-9.

Verhoeven V, Avonts D, Vermeire E, Debaene L, Van Royen P: A short educational intervention on communication skills improves the quality of screening for chlamydia in GPs in Belgium: a cluster randomised controlled trial. Patient Education and Counselling 2005 , 57:101-5.

Poljski C, Atkin L, Williams H: Review of sexual health clinical services in Victoria. Family Planning Victoria, Melbourne 2004.

Samitha Ginige, Christopher K Fairley, Jane S Hocking, Francis J Bowden and Marcus Y Chen. Interventions for increasing chlamydia screening in primary care: a review. BMC Public Health 2007, 7:95

1b.4 Summary of Data on disparities by population group:

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In general, females have higher rates of chlamydia, though they also utilize screening services more often, which may cause misleading statistics (NRCIM, 2009). In 2003, the highest age-specific rates of reported Chlamydia in women were among 15-19 year olds and 20 to 24 year olds. For females ages 10-14, the age-specific rate was 132 per 100,000 (CDC, 2003). Approximately five to 14 percent of 16-20 year olds and three to 12 percent of 20-24 year old women who were routinely screened are infected with Chlamydia (Walsh, 2002).

African American adolescents have the highest rate of chlamydia than any other racial or ethnic group. African American female adolescents have the highest percentage compared to African American males of the same age group (NRCIM, 2009).

1b.5 Citations for data on Disparities:

Centers for Disease Control and Prevention. Trends in Reportable Sexually Transmitted Diseases in the United States, 2003 - National Data on Chlamydia, Gonorrhea and Syphilis. STD Surveillance 2003b.

National Research Council and Institute of Medicine. Adolescent Health Services: Missing Opportunities. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, R.S. Lawrence, J. Appleton Gootman, and L.J. Sim, Editors. Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press. 2009.

Walsh C, Irwin K. Combating the silent chlamydia epidemic. Contemp Ob Gyn 2002;Apr:90-8.

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): Early detection and intervention can prevent the many complications of chlamydia, including pelvic inflammatory disease and infertility.

1c.2-3. Type of Evidence: Evidence-based guideline, Expert opinion

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):

The U.S. Preventive Services Task Force (USPSTF) concluded there is good evidence that screening for chlamydial infection in non-pregnant women who are at increased risk can reduce the incidence of pelvic inflammatory disease (PID). The USPSTF concluded that the benefits of screening women at increased risk are substantial.

While the USPSTF found no studies evaluating the effectiveness of screening for chlamydial infection in pregnant women who are at increased risk, they did find the following:

1. Screening identifies infection in asymptomatic pregnant women.
2. There is a relatively high prevalence of infection among pregnant women who are at increased risk.
3. There is fair evidence of improved pregnancy and birth outcomes for women who are treated for chlamydial infection.

Thus, the USPSTF concluded that the benefits of screening pregnant women who are at increased risk are substantial.

The USPSTF identified no studies documenting the benefits of screening women, including pregnant women, who are not at increased risk for chlamydial infection. While recognizing the potential benefit to women identified through screening, the USPSTF concluded the overall benefit of screening would be small, given the low prevalence of infection among women not at increased risk.

Other guideline-setting bodies generally align with the USPSTF.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*): Good

1c.6 Method for rating evidence: USPSTF based

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1c.7 Summary of Controversy/Contradictory Evidence: Other guideline-setting bodies generally align with the USPSTF, though a few recommend screening for slightly different age ranges. For example, ICSI recommends screening up to age 25 years instead of 24 years.

1c.8 Citations for Evidence (other than guidelines): U.S. Preventive Services Task Force. Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2007 Jul 17;147(2):128-34

Center for Disease Control and Prevention (CDC). Sexually Transmitted Diseases Treatment Guidelines, 2006. *MMWR* August 4, 2006 / 55(RR11);1-94

1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number):

The U.S. Preventive Services Task Force (2007)

The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.

Grade: A Recommendation.

The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.

Grade: B Recommendation.

The USPSTF recommends against routinely providing screening for chlamydial infection for women aged 25 and older, whether or not they are pregnant, if they are not at increased risk.

Grade: C Recommendation.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydial infection for men.

Grade: I Statement.

Institute for Clinical System Improvement (2009)

ICSI recommends routinely screening sexually active women age 25 years and younger.

Grade: Level 1 Evidence (Providers Must Assess)

Centers for Disease Control and Prevention (2010)

Chlamydia Screening Recommendations

During routine health care contacts, assess for infection with chlamydia women who:

are sexually active and 24 years of age or younger,

have new or multiple sexual partners, regardless of age,

have a history of sexually transmitted disease within the last year, regardless of age,

have partners who have had multiple partners within the last year, regardless of age.

Test all pregnant women at least once, regardless of age, including those who plan to terminate the pregnancy.

Re-screen all women who tested positive, especially adolescents, 3-4 months after treatment due to the high incidence of re-infection.

Note: The above recommendations are general guidelines based on national statistics. The prevalence of chlamydia in the immediate geographical area may warrant more or less aggressive screening activities and resources.

American Congress of Obstetricians and Gynecologists (2006)

ACOG recommends routinely screening all sexually active women age 25 years and younger as well as asymptomatic women at high risk for infection.

Grade: Expert Consensus

American Academy of Pediatrics (2006)

AAP recommends at least annual screening of sexually active adolescent females.

<p>Grade: Expert Consensus</p> <p>American Academy of Family Practitioners (2007) Aligns with USPSTF 2007</p> <p>Bright Futures (2008) Bright Futures states that providers should screen sexually active youth age 11-21 years. Grade: Expert Consensus</p> <p>1c.10 Clinical Practice Guideline Citation: American Academy of Family Physicians (AAFP). Summary of recommendations for clinical preventive services. Revision 6.4. Leawood (KS): American Academy of Family Physicians (AAFP); 2007 Aug.</p> <p>American Academy of Pediatrics. Chlamydia trachomatis. Red Book 2006 Report of the Committee on Infectious Diseases. Pickering LK, eds et al. 27th ed. Elk Grove Village, IL. American Academy of Pediatrics; 2006: 252-257</p> <p>American College of Obstetricians and Gynecologists (ACOG). Recommendations from Primary and preventive care: periodic assessments. ACOG Committee Opinion No. 357 (2006)</p> <p>Center for Disease Control and Prevention (CDC). June 2010. Chlamydia Screening and CDC Treatment Recommendations. http://www.health.state.mn.us/divs/idepc/diseases/chlamydia/screentreat.html</p> <p>Institute for Clinical Systems Improvement (ICSI). Preventive services for children and adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2008 Oct. 71 p</p> <p>U.S. Preventive Services Task Force. Screening for chlamydial infection: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i> 2007 Jul 17;147(2):128-34</p> <p>1c.11 National Guideline Clearinghouse or other URL: Preventive services for children and adolescents: http://www.guideline.gov/summary/summary.aspx?doc_id=13314&nbr=006758&string=Chlamydia+AND+Screening</p> <p>1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom): Good</p> <p>1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF): USPSTF based</p> <p>1c.14 Rationale for using this guideline over others: There is broad guideline support for this measure.</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Importance to Measure and Report</i>?</p>	<p>1</p>
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	<p>Eval Rating</p>
<p>2a. MEASURE SPECIFICATIONS</p>	

<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	<p>2a- specs C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2a.1 Numerator Statement (<i>Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome</i>): Children who had documentation in the medical record of chlamydia screening By Age 18 Years</p> <p>2a.2 Numerator Time Window (<i>The time period in which cases are eligible for inclusion in the numerator</i>): 2 years</p> <p>2a.3 Numerator Details (<i>All information required to collect/calculate the numerator, including all codes, logic, and definitions</i>): "Documentation must include a note indicating the date and the following." <ul style="list-style-type: none"> • A chlamydia test result • For abnormal or indeterminate results, evidence of confirmatory testing, referral or treatment" </p>	
<p>2a.4 Denominator Statement (<i>Brief, text description of the denominator - target population being measured</i>): "Children who turned 18 years of age between January 1 of the measurement year and December 31 of 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. Additional denominator criterion: Only include women with evidence of sexual activity. Evidence of sexual activity can include the following: <ul style="list-style-type: none"> • Documentation of sexual activity • Prescription for contraception • Treatment or Screening for sexually transmitted disease • Pregnancy • Pelvic examination </p> <p>2a.5 Target population gender: Female 2a.6 Target population age range: 13 years-18 years</p> <p>2a.7 Denominator Time Window (<i>The time period in which cases are eligible for inclusion in the denominator</i>): 1 year</p> <p>2a.8 Denominator Details (<i>All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions</i>): See above; chart review only</p>	
<p>2a.9 Denominator Exclusions (<i>Brief text description of exclusions from the target population</i>): Exclude males</p> <p>2a.10 Denominator Exclusion Details (<i>All information required to collect exclusions to the denominator, including all codes, logic, and definitions</i>): See above; chart review only</p>	
<p>2a.11 Stratification Details/Variables (<i>All information required to stratify the measure including the stratification variables, all codes, logic, and definitions</i>): None</p>	
<p>2a.12-13 Risk Adjustment Type: No risk adjustment necessary</p>	
<p>2a.14 Risk Adjustment Methodology/Variables (<i>List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method</i>): NA</p>	
<p>2a.15-17 Detailed risk model available Web page URL or attachment:</p>	

<p>2a.18-19 Type of Score: Rate/proportion</p> <p>2a.20 Interpretation of Score: Better quality = Higher score</p> <p>2a.21 Calculation Algorithm (<i>Describe the calculation of the measure as a flowchart or series of steps</i>): 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.</p>
<p>2a.22 Describe the method for discriminating performance (<i>e.g., significance testing</i>): Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance</p>
<p>2a.23 Sampling (Survey) Methodology <i>If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):</i> 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.</p>
<p>2a.24 Data Source (<i>Check the source(s) for which the measure is specified and tested</i>) Paper medical record/flow-sheet, Electronic clinical data, Electronic Health/Medical Record</p>
<p>2a.25 Data source/data collection instrument (<i>Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.</i>): Medical Record</p>
<p>2a.26-28 Data source/data collection instrument reference web page URL or attachment:</p>
<p>2a.29-31 Data dictionary/code table web page URL or attachment:</p>
<p>2a.32-35 Level of Measurement/Analysis (<i>Check the level(s) for which the measure is specified and tested</i>) Clinicians: Individual, Clinicians: Group, Population: national, Population: regional/network</p>
<p>2a.36-37 Care Settings (<i>Check the setting(s) for which the measure is specified and tested</i>) Ambulatory Care: Office, Ambulatory Care: Clinic, Ambulatory Care: Hospital Outpatient</p>
<p>2a.38-41 Clinical Services (<i>Healthcare services being measured, check all that apply</i>) Clinicians: Nurses, Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)</p>

TESTING/ANALYSIS

<p>2b. Reliability testing</p> <p>2b.1 Data/sample (<i>description of data/sample and size</i>): NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)</p> <p>2b.2 Analytic Method (<i>type of reliability & rationale, method for testing</i>): We did not conduct reliability testing for this measure.</p> <p>2b.3 Testing Results (<i>reliability statistics, assessment of adequacy in the context of norms for the test conducted</i>): We did not conduct reliability testing for this measure.</p>	<p>2b</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>): NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>): NCQA tested the measure for face validity using a panel of stakeholders with specific expertise in</p>	<p>2c</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>measurement and child health care. This panel included representatives from key stakeholder groups, including pediatricians, family physicians, health plans, state Medicaid agencies and researchers. Experts reviewed the results of the field test and assessed whether the results were consistent with expectations, whether the measure represented quality care, and whether we were measuring the most important aspect of care in this area. This measure was deemed valid by the expert panel. In addition, this measure does not utilize administrative data sources; data recorded in the chart is considered the gold standard.</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>): Elig Population: 52 Screening documented: 61.5 Results documented: 57.7 Results and Proper Follow Up Documented 48.0</p>	
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s): NA</p> <p>2d.2 Citations for Evidence: NA</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>): NA</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>): NA</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>): NA</p>	<p>2d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>): NA</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>): NA</p> <p>2e.3 Testing Results (<i>risk model performance metrics</i>): NA</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale: The measure assesses prevention and wellness in the general population; risk adjustment is not indicated.</p>	<p>2e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (<i>description of data/sample and size</i>): NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (<i>type of analysis & rationale</i>): Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance</p> <p>2f.3 Provide Measure Scores from Testing or Current Use (<i>description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningful differences in performance</i>): Upon reviewing the measure, the expert panel suggested adding an exclusion for children already diagnosed or in treatment. Note, this exclusion is not evidence dependent but rather a specification issue.</p>	<p>2f C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2g. Comparability of Multiple Data Sources/Methods</p>	<p>2g</p>

<p>2g.1 Data/sample (<i>description of data/sample and size</i>): NCQA received data from 19 physician practices who submitted 10 records per measure (total 190 records per measure)</p> <p>2g.2 Analytic Method (<i>type of analysis & rationale</i>): This measure is chart review only; no other sources were identified by the expert panel; this measure does not utilize administrative data</p> <p>2g.3 Testing Results (<i>e.g., correlation statistics, comparison of rankings</i>): NA</p>	<p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (<i>scores by stratified categories/cohorts</i>): The measure is not stratified to detect disparities.</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans: NA</p>	<p>2h</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
3. USABILITY	
<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: Not in use but testing completed</p> <p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (<i>If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years</i>): This measure is not currently publicly reported. NCQA is exploring the feasibility of adding this measure and its related measures into a physician-level program and/or the HEDIS® measurement set as appropriate.</p> <p>3a.3 If used in other programs/initiatives (<i>If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years</i>): This measure is not currently used in QI. NCQA is exploring the feasibility of adding this measure and its related measures into a physician-level program and/or the HEDIS® measurement set as appropriate. NCQA anticipates that after we release these measures, they will become widely used, as all our measures do.</p> <p>Testing of Interpretability (<i>Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement</i>)</p> <p>3a.4 Data/sample (<i>description of data/sample and size</i>): NA</p> <p>3a.5 Methods (<i>e.g., focus group, survey, QI project</i>): NCQA vetted the measures with its expert panel. In addition, throughout the development process, NCQA vetted the measure concepts and specifications with other stakeholder groups, including the National Association of State Medicaid Directors, NCQA’s Health Plan Advisory Council, NCQA’s Committee on Performance Measurement, and the American Academy of Pediatrician’s Quality Improvement Innovation Network.</p>	<p>3a</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>After field testing, NCQA also conducted a debrief call with field test participants. In the form of a group interview, NCQA systematically sought feedback on whether the measures were understandable, feasible, important, and had face validity.</p> <p>3a.6 Results (<i>qualitative and/or quantitative results and conclusions</i>): NCQA received feedback that the measure is understandable, feasible, important and valid.</p>	
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related <u>endorsed</u> or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already <u>endorsed by NQF</u> (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population): 3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value 3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality: NCQA’s Chlamydia Screening HEDIS measure is currently NQF endorsed; however, this measure is for health plan level of measurement. In addition, the HEDIS measure does not currently assess follow-up of abnormal results.</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Usability</i>?</p>	<p>3</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Usability</i>, met? Rationale:</p>	<p>3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
4. FEASIBILITY	
<p>Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>4a. Data Generated as a Byproduct of Care Processes</p> <p>4a.1-2 How are the data elements that are needed to compute measure scores generated? Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)</p>	<p>4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4b. Electronic Sources</p> <p>4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) No</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers. NCQA plans to eventually adapt this measure for use in electronic health records.</p>	<p>4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. 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.</p>	<p>4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4e. Data Collection Strategy/Implementation</p> <p>4e.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/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: 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.</p> <p>4e.2 Costs to implement the measure (costs of data collection, fees associated with proprietary measures): Collecting measures from medical charts is time-consuming and can be burdensome. Adapting this measure in electronic health records may relieve some of this burden.</p> <p>4e.3 Evidence for costs: Based on field test participant feedback and other stakeholder input.</p> <p>4e.4 Business case documentation:</p>	<p>4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i>?</p>	<p>4</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
RECOMMENDATION	
<p>(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.</p>	<p>Time-limited <input type="checkbox"/></p>
<p>Steering Committee: Do you recommend for endorsement? Comments:</p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/></p>
CONTACT INFORMATION	
<p>Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia,</p>	

20005
<p>Co.2 Point of Contact Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-</p>
<p>Measure Developer If different from Measure Steward Co.3 Organization National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005</p>
<p>Co.4 Point of Contact Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-</p>
<p>Co.5 Submitter If different from Measure Steward POC Sepheen, Byron, MHS, byron@ncqa.org, 202-955-3573-, National Committee for Quality Assurance</p>
<p>Co.6 Additional organizations that sponsored/participated in measure development</p>
<p>ADDITIONAL INFORMATION</p>
<p>Workgroup/Expert Panel involved in measure development Ad.1 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 Jessie Sullivan</p>
<p>Ad.2 If adapted, provide name of original measure: NA Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: Ad.7 Month and Year of most recent revision: Ad.8 What is your frequency for review/update of this measure? Ad.9 When is the next scheduled review/update for this measure?</p>
<p>Ad.10 Copyright statement/disclaimers: © 2009 by the National Committee for Quality Assurance 1100 13th Street, NW, Suite 1000 Washington, DC 20005</p>
<p>Ad.11 -13 Additional Information web page URL or attachment:</p>
<p>Date of Submission (MM/DD/YY): 08/30/2010</p>